Colorado School of Mines Employee Injury Statement

Date & Time of Accident: _____

Employee Name: _____ **DOB:** _____

Contact Phone: _____ **Address:** _____

City: _____ **State:** _____ **Zip code:** _____

Job Title: _____ **Date of Hire:** _____

Status: Full-Time **Part-Time** **Department:** _____ **Salary:** _____

Supervisor's Name: _____ **Work Phone:** _____

Description of Accident & Injury

Location of Injury (address & building name): _____

_____

What happened to cause the injury? What activity(s) were you engaged in at the time of injury?

_____
_____
_____
_____
_____
_____

Equipment being used at the time of injury: _____

_____

Specify what body part(s) were injured. Please be specific, (left, right, lower, upper, etc.

_____
_____
_____

Time away from work due to injury (days/hours): _____

Last Day Worked: _____

Returned to Work (yes/no):_____ **Date Returned:** _____ **Estimated Date to Return:** _____

Name of Witness(s): _____ **Witness(s) Contact Phone Number:** _____

Additional Comments: _____

_____
_____
_____
_____

Your Signature: _____ **Date:** _____

Report all injuries immediately! Please print clearly and submit completed form to the Mines Human Resource Office located in the Guggenheim building or email to benefits@mines.edu