TOWN OF COLMA
SHORT FORM – ACCIDENT OR INJURY

Name of Injured Employee: _____

Employee's Department: _____

Date of Accident or Injury:_____Time of Injury:_____

Location Where Accident/Injury Occurred: _____

Name(s) of Witness(es) to Accident/Injury: _____

Describe in Detail How Accident or Injury Occurred:

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_____
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_____

I have declined the offer of medical treatment for the injury described above. If I should require medical treatment at a later date, I will immediately inform my supervisor and Human Resources.

Signature of Employee_____Date:_____

Signature of Supervisor_____Date:_____

Signature of Manager/Director_____Date:_____

Original of this form is to be routed to Human Resources to be retained in the employee's Workers' Compensation file.