ARIZONA WESTERN COLLEGE
HUMAN RESOURCES DEPARTMENT
WORK RELATED NOTICE OF INJURY

NOTE: THIS FORM IS FOR INJURIES WHICH OCCUR ON THE JOB

Date:_____

Name_____DOB_____SS#_____

Address_____Phone #_____

Legal Marital Status: Single Married Divorced Widow(er) Sex: Male Female

Date of Hire_____ Occupation_____Date & Time of Injury_____

Date reported to Supervisor /HR Benefits Manager_____No medical treatment needed at this time_____

If treated, provide location_____
(AWC's designated health facilities for work injuries are Agile Occupational Medicine and Prime Care)

Nature of Injury_____Body Part_____Side Injured_____

Describe cause of accident_____

_____

Location of Accident_____

What activity were you doing right before the injury?_____

What caused the injury to happen?_____

Work Schedule:
Number of Days Per Week Usually Worked _____Hours Per Day Worked_____
Time Working Hours Begin_____Time Working Hours End_____
Last Day of Work After Injury_____Date Returned to Work_____

If another person (non AWC employee) caused accident, provide name and address _____
_____

Insurance Carrier information: **Copperpoint Western Insurance Company** **Policy number 1003230**
PO Box 33069
Phoenix AZ 85067

Most injuries can be treated at an Urgent Care. The hospital emergency room should be used only for serious injuries that require specialized care or services.

Human Resource action taken_____

Original copy must be submitted to Human Resources/Benefits Manager Revised 05/2024