

EMPLOYEE REPORT OF INJURY OR OCCUPATIONAL ILLNESS

Employee Identification

1. Name			2. Home Mailing Address			
3. Department		4. Work Phone			5. Hire Date	
6. Banner ID No.	7. Birth Date	8. Gender	9. Job Title	10. on University Property? on University Business?		Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

Part 1 – Injury or Illness Information (To be completed by Employee)

11. Date of incident: _____ 2. Time: _____ A.M. or P.M. 3. Date & Time reported to Supervisor _____

14. Description of events leading to injury – where were you, what were you doing, cause of injury, etc. (Be specific):

15. Witnesses: Yes No ; if yes:
(1) _____
Name Dept. Phone
(2) _____
Name Dept. Phone

16. Part of Body Injured

	Left	Right	Left	Right	
<input type="checkbox"/>	Face / Teeth				
<input type="checkbox"/>	Head				
<input type="checkbox"/>	Abdomen				
<input type="checkbox"/>	Back Lower				
<input type="checkbox"/>	Back Mid				
<input type="checkbox"/>	Back Upper				
<input type="checkbox"/>	Groin				
<input type="checkbox"/>	Neck (cervical)				
<input type="checkbox"/>	Nose / Throat / Lungs				

<input type="checkbox"/> Hand	<input type="checkbox"/> Elbow	<input type="checkbox"/> Ankle
<input type="checkbox"/> Thumb	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Foot
<input type="checkbox"/> Finger(s)	<input type="checkbox"/> Thigh	<input type="checkbox"/> Toe(s)
<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Eye
<input type="checkbox"/> Arm	<input type="checkbox"/> Calf	<input type="checkbox"/> Ear

Laceration Sprain
 Puncture Strain
 Insect / Animal Bite Fracture / Dislocation
 Burn Inhalation
 Abrasion Foreign Matter
 Contusion Skin Irritation

Other – Show in Remarks

In Case of Back Strain, Abdominal Regions, or Hernia, Answer Items 19 through 22:

18. Approximate weight of object handled _____ lbs. How high was it lifted? _____ feet Was this kind of work performed regularly? Yes No

19. Were you subject to unusual strain or circumstances? Yes No if yes, explain:

20. Did injury appear immediately? Yes No if no, explain:

21. Did you slip, fall, or strike yourself? Yes No if yes, explain:

Was first aid given? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you go to the Doctor? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give Doctor's name: _____ Did you go to hospital? Urgent Care? <input type="checkbox"/> University Health Care? <input type="checkbox"/> If hospital / care facility, please give name and address: _____ _____	Have you filed for Workers' Compensation before? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, where? _____ Nature of previous claims? _____ Is this injury a recurrence or aggravation of an old injury? Yes <input type="checkbox"/> No <input type="checkbox"/>
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I, the injured employee, herein certify that the information set forth above is true and correct to the best of my knowledge.

Part II – Statement of Supervisor (To be completed as an INDEPENDENT report from Employee’s Report)

Employee Name: _____	Date of Incident: _____
I personally witnessed this accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
List exact nature of injury and apparent cause of accident: _____ _____ _____	

Answer the following questions in relation to the cause of the accident.

1. Was the employee using approved methods in performing a duty at the time of the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the employee using safety equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Was the employee required to wear safety equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. If mechanical equipment was involved, was the employee trained in use of equipment and/or procedures related to job functions? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Was the equipment faulty? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Did the employee commit an unsafe act? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Was any immediate corrective action taken? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____ _____	

State any inconsistencies you found while investigating employee’s statements: _____ _____ _____	
<input type="checkbox"/> I have investigated this incident and agree that the injury did occur while the employee was on duty and as he / she described above. <input type="checkbox"/> I feel that further investigation of this incident is required.	
_____ Supervisor’s Signature	_____ Date Injury Reported to Supervisor
	_____ Date Report Completed

Part III – Statement of Witness (if applicable)

Name of Witness: _____	
I Personally Witnessed The Incident Involving: (name of Injured Employee) _____	
I believe that a true description of the incident is the following: _____ _____ _____	
(Signature)	(Date)
Name of Witness: _____	
I Personally Witnessed The Incident Involving: (name of Injured Employee) _____	
I believe that a true description of the incident is the following: _____ _____ _____	
(Signature)	(Date)

IMPORTANT NOTES:

1. Please remember that the purpose of an incident investigation is not to find blame but to prevent future incidents. Investigate each incident fully to uncover all underlying causes so that corrective actions can be taken to prevent similar incidents in the future.
2. Please provide all information required for both Parts I and II including witness statements.
3. The completed form should be forwarded to the Environmental Health and Safety Office no later than two (2) business days after the incident occurs.