Kent STATE UNIVERSITY

EMPLOYEE REPORT
OF INJURY OR OCCUPATIONAL ILLNESS

Case No. _____
(To be completed by Safety Ofc.)

DUPLICATE COPIES
Type or Print With Ball Point Pen

EMPLOYEE IDENTIFICATION

1. NAME	2. HOME ADDRESS		
3. HOME PHONE	4. DEPARTMENT	5. WORK PHONE	6. LENGTH OF KSU EMPLOYMENT

7. S.S. NO.	8. BIRTH DATE	9. SEX	10. JOB TITLE	11. on University Property? Yes ☐ No ☐ on University Business? Yes ☐ No ☐

PART I — INJURY OR ILLNESS INFORMATION (To be completed by EMPLOYEE)

12. Date of incident _____ 13. Time _____ am pm 14. Date & Time reported to Supervisor _____

15. Description of events leading to injury — where were you, what were you doing, cause of injury, etc. *(Be Specific):* _____

16. Witnesses: NO ☐ YES ☐; if yes:

(1) _____ Name _____ Dept. Phone

(2) _____ Name _____ Dept. Phone

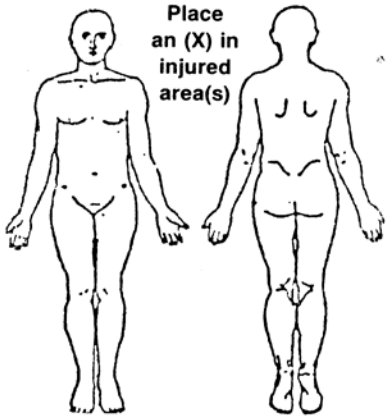
17. Part of Body Injured

Left	Right		Left	Right		Left	Right		
☐	☐	Hand	☐	☐	Elbow	☐	☐	Ankle	☐ Face/Teeth
☐	☐	Thumb	☐	☐	Shoulder	☐	☐	Foot	☐ Head
☐	☐	Finger(s)	☐	☐	Thigh	☐	☐	Toe(s)	☐ Abdomen
☐	☐	Wrist	☐	☐	Knee	☐	☐	Eye	☐ Back Lower
☐	☐	Arm	☐	☐	Calf	☐	☐	Ear	☐ Back Mid
									☐ Back Upper
									☐ Groin
									☐ Neck (cervical)
									☐ Nose/Throat/Lungs

18. Nature of Injury

☐ Laceration ☐ Puncture ☐ Insect/Animal Bite ☐ Burn ☐ Abrasion ☐ Contusion
☐ Sprain ☐ Strain ☐ Fracture/Dislocation ☐ Inhalation ☐ Foreign Matter ☐ Skin Irritation
☐ Other — Show in Remarks _____

Place an (X) in injured area(s)



IN CASE OF BACK STRAIN, ABDOMINAL REGIONS OR HERNIA, ANSWER ITEMS 19 THROUGH 22:

19. Approximate weight of object handled _____ How high lifted? _____ Was kind of work performed regularly? ☐ NO ☐ YES

20. Were you subject to unusual strain or circumstances? ☐ NO ☐ YES; if yes, explain: _____

21. Did injury appear immediately? ☐ YES ☐ NO; if no, explain: _____

22. Did you slip, fall or strike yourself? ☐ NO ☐ YES; if yes, explain: _____

Was first aid given? ☐ YES ☐ NO

Did you go to Doctor? ☐ NO ☐ YES; if yes, name doctor:

_____

Did you go to hospital? ☐ Urgent Care ☐ University Health Center ☐
If hospital/care facility, please give name and address:

_____

Have you filed for Workers' Compensation before?

☐ NO ☐ YES; if yes, where: _____

_____

Nature of previous claims _____

_____

Is this injury a recurrence or aggravation of an old injury? ☐ YES ☐ NO

I, the injured employee, herein certify that the information set forth above is true and correct to the best of my knowledge.

White - Personnel
Canary - Environmental Health Office
Pink - Department

_____
Employee's Signature Date Signed