EMPLOYEE'S REPORT OF WORK RELATED INJURY OR ILLNESS

In order to prevent work related injuries and accidents, it is necessary to know how and why they occur. Please state the facts relating to this incident as accurately as possible. If you are unable to complete this form, please do not hesitate to ask for assistance.

Name _____ **Date** _____

Home Phone (____)_____ **Cell Phone (____)**_____

Address _____ **City** _____ **Zip Code** _____

Social Security # _____ ***Sex:*** ☐*female* ☐*male* **Date of Birth** _____

Department _____ **Job Title** _____ **Shift** *(start)* _____ *(end)*_____

Number of hours usually worked _____ **Number of days per week** _____

Please check the days of the week that you work on a regular schedule:

Mon.____ **Tues.** ____ **Weds.** ____ **Thurs.** ____ **Fri.** ____ **Sat.** ____ **Sun.** ____

Injury Date _____ **Injury Time** _____ am/pm

Did accident happen on campus? ☐*yes* ☐*no* **Date Supervisor was notified** _____

Where did this injury occur? _____

What were you doing when the injury occurred? _____

_____

How did the injury occur? *(Describe fully what happened and how it happened)* _____

_____

_____

_____

_____

_____

_____

Describe the Injury *(cut, strain, bruise, etc.)* _____

Part of the body affected *(be specific)* _____

Name of Witness *(if any)* _____

Employee's signature _____ **Date** _____

Completed by _____ **Date**_____

(If completed by person other than employee)

Please complete this form immediately and return it to your Supervisor or Human Resources.

Revised: 1/29/10 (H:/forms/Employee Injury Report)