EMPLOYEE INCIDENT REPORT FORM (Form 5-WC)

(To Be Completed by Employee and Supervisor Within 24 Hours of an Accident or Injury)
NOTE: No bills can be paid until we receive this form.

Today's Date: ______________________ **Employee ID Number:** 991 - ____ - ______

Employee Name: ______________________ **Job Title:** ______________________

Home Address: ____

Date of Birth: ______________ **Date of Hire:** ______________

Department Name: ______________________ **Department Org #:** ______

Department Phone #: ______________ **Employee's Supervisor:** ______________________

Date of Incident: ______________________ **Time of Incident:** __________ ☐ AM ☐ PM

Location of Incident (building and area where injury occurred)**:** ______________________

Please explain your injury and how it happened: (i.e., lifting bed & sprained back; tripped over vacuum cord, fell & hit arm)

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Check Specific Type of Injury or Illness:

☐ Fracture ☐ Foreign Body ☐ Bruises ☐ Other: ______________________

☐ Burns ☐ Sprain or Strain ☐ Cut ______________________

Check Part(s) of Body Affected:

☐ Left ☐ Head ☐ Face and Neck ☐ Eyes ☐ Trunk

☐ Right ☐ Arms ☐ Hands ☐ Legs ☐ Other: ______________________

☐ Upper Back ☐ Lower Back ☐ Feet ______________________

List all equipment, materials, and chemicals the employee was using when the incident occurred:

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Did the employee go to the Center for Occupational Health for medical treatment? ☐ Yes ☐ No

Did the employee go to the hospital for emergency medical treatment? ☐ Yes ☐ No

Has the employee missed any time due to the injury? ☐ Yes ☐ No

If yes, please list dates and times missed: ______________________

Witness(es) to the incident? ☐ Yes ☐ No **If yes, please provide name(s) and phone number(s):**

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I certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. Furthermore, I understand the University or its representatives may audit the information I supplied. I understand that falsifying this document may be grounds for disciplinary action up to and including termination of employment. In addition, I may be in violation of Federal and/or State laws and subject to prosecution.

Employee Signature: ______________________ Date: ________

Supervisor Signature: ______________________ Date: ________

Department Head Signature: ______________________ Date: ________

For Workers Comp Dept. Use Only
Rate of Pay: week / month
Level 1 Org:
SSN:

Please send completed form to Marvin Seger, Workers Compensation, College of Business Room 1203. Any questions, call ext. 4143.