**Case No.**
**(To be completed by Safety Office)**

# 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? Yes ☐ No ☐<br>on University Business? Yes ☐ No ☐ |

## 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 | | 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 |

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

## 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 ☐ No
Did you go to the Doctor? ☐ Yes ☐ No; If yes, give Doctor's name:

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

Have you filed for Workers' Compensation before? ☐ Yes ☐ No; 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.

Employee's Signature Date Signed

1 Original – Occupational Health and Safety Office
1 Copy - Personnel
1 Copy - Department

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## 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:** ☐ Yes ☐ 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?** ☐ Yes ☐ No
2. **Was the employee required to wear safety equipment?** ☐ Yes ☐ No **Was the employee using safety equipment?** ☐ Yes ☐ No
3. **If mechanical equipment was involved, was the employee trained in use of equipment and/or procedures related to job functions?** ☐ Yes ☐ No
4. **Was the equipment faulty?** ☐ Yes ☐ No
5. **Did the employee commit an unsafe act?** ☐ Yes ☐ No
6. **Was any immediate corrective action taken?** ☐ Yes ☐ No **If yes, what?**

**State any inconsistencies you found while investigating employee's statements:**

☐ **I have investigated this incident and agree that the injury did occur while the employee was on duty and as he / she described above.**

☐ **I feel that further investigation of this incident is required.**

_____
**Date Injury Reported to Supervisor**

_____ _____
**Supervisor's Signature** **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 Occupational Health and Safety Office no later than two (2) business days after the incident occurs.**

**1 Original – Occupational Health and Safety Office**
**1 Copy - Personnel**
**1 Copy - Department**

**Revised 02/01/2008**