FIRST REPORT OF INJURY OR ILLNESS (Work Comp Only)

Employee Information (To be completed by injured or sick worker.)

Name (Last, First, M.I.)			Gender F M	List Witnesses	
Social Security Number	Home Phone		Date of Birth (m/d/y)	Worksite Location of Injury (stairs, dock, etc.)(be specific)	
Mailing or Home Address				Nature of Injury (bruise, laceration, etc.)	Part of Body Injured or Exposed (ex: right foot)
City	State		Zip Code	Date Injury Reported to Supervisor (m/d/y)	Time Injury Reported to Supervisor am pm
Occupation/Job Title		Department		Did Employee Seek Medical Attention? Yes No *If no, does employee expect to : Yes No	
Employee Type: Faculty Salaried Hourly Student Temp EE Other				Medical Provider (Doctor's Name) or Facility	Medical Provider Phone Number
Does the Employee Speak English? Yes No *If no, specify language:				Mailing Address	
Date of Injury (m/d/y)		Time of Injury am pm		City	State / Zip Code

Employee Description of Injury/Illness	
Employee Signature	Date

Witness Report of Injury/Illness (To be completed by witness.)

Witness Name (Last, First, M.I.)	Witness Work Phone	Witness Occupation/Job Title	Witness Department
Witness Description of Injury/Illness			
Witness Signature		Date	

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Supervisor Report of Injury/Illness (To be completed by supervisor.)

Supervisor Name (Last, First, M.I.)	Supervisor Work Phone	Supervisor Occupation/Job Title	Supervisor Department
Employee Shift/Scheduled Hours (ex: M-F, 8am – 4pm)	Did Employee Miss Work? *If yes, what are dates missed? Yes No	Was Employee Performing Regular Job Duties? *If no, please specify Yes No	
If safety equipment was provided, was it used? *If no, please explain. Yes No		Was an unsafe act being performed? *If yes, please describe Yes No	
Supervisor Description of Injury/Illness			
What can be done to prevent this type of injury in the future?			
Supervisor Signature		Date	

Employer Report of Injury/Illness (To be completed by human resources.)

Date of Hire	How long in current position?	Was employee paid for the full day of injury? Yes No	Is Employee an Owner, Partner, or Officer? Yes No
Rate of Pay Hourly Weekly	Additional Bonus, Commission, Overtime	Claim Number (from work comp carrier)	
Human Resources Signature		Date	

Form must be returned to Human Resources within 5 calendar days of the injury or illness.

Fax #: 403-3983
Phone #: 403-3982