Initial Report of Injury

Instructions: Complete this form following an injury to provide general details on the incident so that Human Resources may authorize medical treatment and/or report the injury to the worker's compensation insurance provider for further handling.

Employee Name:_____ Contact #:_____

Supervisor: _____ Department: _____

Job Title: _____

Check One: _____Faculty _____Staff _____Student Worker

Date of Injury:_____ Time:_____

Location:_____

What was the person doing when the injury occurred? _____

_____

_____

Describe in detail how the incident occurred. Include any unsafe acts and/or conditions.

_____

_____

_____

Describe injury and affected body parts.

_____

_____

_____

Was there a machine, tool, substance, or object related to the incident? ____No ____Yes

If yes, please explain: _____

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Please return this form to Human Resources as soon as is practicable following an injury.