



Employee's Report

OCCUPATIONAL INJURY/ILLNESS

TO BE SUBMITTED WITHIN **TWO DAYS** OF OCCURRENCE.

Name (*print*) _____ Job Title _____

1. College _____ 2. Department _____ 3. Department Phone _____

4. Date of injury/illness _____ 5. Approximate Time of injury/illness AM PM

6. Time work shift began _____ 7. Building where injury took place _____ 8. Floor/Room where injury took place _____

9. Please describe fully how injury/illness occurred and indicate what you were doing at the time. (*describe below*)

10. Please describe the injury/illness (*describe below*)

11. Body part(s) affected _____ 12. left right

13. Type of Accident (*check all that apply*)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Animal/Insect Bite | <input type="checkbox"/> Collision (car/vehicle) | <input type="checkbox"/> Foreign Body in Eye | <input type="checkbox"/> Contact with Hot Object |
| <input type="checkbox"/> Electrical Contact | <input type="checkbox"/> Fall (different/same level) | <input type="checkbox"/> Material Handling | <input type="checkbox"/> Repetitive Motion |
| <input type="checkbox"/> Contusion (bruise) | <input type="checkbox"/> Fall (liquid/grease spill) | <input type="checkbox"/> Strain | <input type="checkbox"/> Contact with Chemical |
| <input type="checkbox"/> Laceration/Puncture | <input type="checkbox"/> Other (<i>describe below</i>) | | |

14. Were there any witnesses to your injury/illness? Yes No

15. If "Yes," name of person(s) _____

16. Have you received medical care for this condition? Yes No

17. Do you wish to receive medical treatment? Yes No

18. If you have received medical treatment for this condition, please provide the following information: Date Seen | Doctor's Name and Address _____

19. Have you had a similar condition before? Yes No

20. If so, when? _____

21. In your opinion, what can be done to prevent such an accident from happening again? (*describe below*)

I HAVE READ THIS STATEMENT AND IT IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature _____

Date _____