

EMPLOYEE'S INJURY/ILLNESS REPORT FORM

Complete, sign, and return this form to Human Resources within 24 hours of injury/illness.

Part 1 – Personal Information

Employee's Name _____

Social Security Number _____

Home Address _____

Date of Birth _____

Gender Male Female

Phone _____

Part 2 – Employment Information

Job Title _____

Part-time Full-time

Department _____

Department Phone _____

Work Schedule (i.e. M-F, 9am-5pm) _____

Part 3 – Incident Details

Incident Day & Date _____ Incident Time _____ am _____ pm Reported to Security? _____

Location/Address (Bldg, Rm, Off-site location) _____

Time you reported to work on day of incident _____

Dates of absence, if any, due to this incident _____

Nature of Incident

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Bite | <input type="checkbox"/> Laceration |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Strain/sprain |
| <input type="checkbox"/> Cut | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Puncture |
| Other _____ | |

Location of Bodily Injury

- | | | | | |
|----------------------------------|-------------------------------------|------------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Ear | <input type="checkbox"/> Finger* | <input type="checkbox"/> Head | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Elbow | <input type="checkbox"/> Foot | <input type="checkbox"/> Knee | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Back | <input type="checkbox"/> Eye | <input type="checkbox"/> Forearm | <input type="checkbox"/> Leg | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Face | <input type="checkbox"/> Hand | <input type="checkbox"/> Mouth | <input type="checkbox"/> Wrist |
| | <input type="checkbox"/> Right Side | <input type="checkbox"/> Left Side | | |
| Other _____ | | | | |
| *Identify which finger _____ | | | | |

What were you doing when injured? (Be specific) _____

How did the injury occur? _____

What object or substance directly harmed you? (i.e. concrete floor, chlorine, staple gun) _____

Action taken to prevent incident recurrence _____

Names of witnesses & contact info _____

Medical Treatment Provided: First Aid by Staff FIT Health Services Taken to Hospital
 Refused Medical Aid Self-referred to private physician or healthcare facility

Name, address and phone of physician or hospital _____

Part 4 – Certification Employee's signature is required. The supervisor/administrator attests only that the facts are accurate to the best of his/her knowledge or as presented to him/her.

Employee Signature _____ Date _____

Supervisor/Administrator Signature _____ Date _____