

## **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 reoccurrence \_\_\_\_\_

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 \_\_\_\_\_