

**REPORT OF OCCUPATIONAL
INJURY OR ILLNESS**

Any person who makes or causes to be made any knowingly false or fraudulent material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

FORM TO BE COMPLETED IMMEDIATELY AFTER INCIDENT

EMPLOYEE	NAME: Last First M.I.	SOCIAL SECURITY NUMBER:	SEX: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	TODAY'S DATE: / /	
	HOME ADDRESS	CITY	STATE	ZIP	
	DEPARTMENT - DESIGNATED CAMPUS ASHBY <input type="checkbox"/> HERRICK <input type="checkbox"/> SUMMIT <input type="checkbox"/>	JOB TITLE (no abbreviations)	UNION LOCAL	HIRE DATE:	
	HOURS USUALLY WORKED PER DAY _____ DAYS/WEEK _____ TOTAL WEEKLY HOURS _____	EMPLOYMENT STATUS: Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Volunteer <input type="checkbox"/> Per Diem <input type="checkbox"/>			
	DATE OF INCIDENT:	TIME OF INCIDENT:	TIME BEGAN WORK:	MANAGER/SUPERVISOR:	Ext: _____
	DEPARTMENT WHERE INCIDENT OCCURRED (Give bldg., floor, room no.)			LAST DAY WORKED:	
	INCIDENT REPORTED TO IMMEDIATE SUPERVISOR Name: _____ Date: _____		OTHER EMPLOYEES INJURED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
	DID ANYONE WITNESS THIS INCIDENT? NO <input type="checkbox"/> YES <input type="checkbox"/> NAME(S) _____			PERSONAL PROTECTIVE EQUIPMENT USED? YES <input type="checkbox"/> NO <input type="checkbox"/>	

CAUSE	WHAT WERE YOU DOING WHEN THE INCIDENT OCCURRED? (i.e., Lifting/moving patient, cleaning floor, typing)
	HOW DID THE INCIDENT OCCUR? (i.e., Removing boxes from a materials cart, bent over and felt pain in my back)

NATURE	SPECIFY EXACT TYPE OF INJURY: (i.e., Cut, Strain/Sprain, Exposure, Puncture)	BODY PART: (i.e., Right middle finger, low mid back) LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>
	HAVE YOU EVER HAD THIS TYPE OF INJURY BEFORE? NO <input type="checkbox"/> YES <input type="checkbox"/>	List Prior Injury Dates: _____

_____ I decline evaluation at this time _____ I will contact Employee Health Services, *immediately*, regarding evaluation

NAME OF PRIMARY CARE PHYSICIAN: _____ PHONE: _____

I certify that all of the foregoing information is true, correct and complete and that I have not omitted any pertinent information

EMPLOYEE SIGNATURE: _____ DATE: _____

COMMENTS: _____

SUPV	<input type="checkbox"/> UNSAFE WORK ENVIRONMENT (Unsafe Condition Form completed and Forwarded to Safety on: _____) <input type="checkbox"/> UNSAFE WORK PRACTICE
	IMMEDIATE ACTION TAKEN: _____ IMMEDIATE SUPERVISOR: _____ (Signature of person in charge required) Date: _____

EMPLOYEE TREATMENT AND DISPOSITION

SENT TO EMERGENCY DEPARTMENT SENT TO EMPLOYEE HEALTH SEEN BY PRIVATE PHYSICIAN (Name of MD) _____

NO INJURY - TREATMENT NOT NECESSARY OTHER: _____

SUPERVISOR/MANAGER - COMPLETE AND SEND TO SAFETY WITHIN 72 HOURS

DATE OF EMPLOYEE INTERVIEW: _____

CAUSE OF INCIDENT	PLEASE CHECK ALL THAT APPLY IN EACH CATEGORY			
	ACTIVITY	TYPE OF EXPOSURE	CAUSE	
	<input type="checkbox"/> BENDING	<input type="checkbox"/> BODY FLUIDS	<input type="checkbox"/> PATIENT HANDLING	<input type="checkbox"/> PHYSICAL CONTACT WITH PATIENT/VISITOR
	<input type="checkbox"/> CARRYING	<input type="checkbox"/> HAZARDOUS MATERIALS	<input type="checkbox"/> MATERIAL HANDLING	<input type="checkbox"/> PHYSICAL CONTACT WITH CO-WORKER
	<input type="checkbox"/> PUSHING/PULLING	<input type="checkbox"/> GAS, FUMES OR VAPORS	<input type="checkbox"/> SLIP, TRIP OR FALL - SAME LEVEL	<input type="checkbox"/> CAUGHT IN OR BETWEEN
	<input type="checkbox"/> LIFTING		<input type="checkbox"/> SLIP, TRIP OR FALL - DIFFERENT LEVEL	<input type="checkbox"/> STRUCK BY STRIKING AGAINST
	<input type="checkbox"/> REACHING		<input type="checkbox"/> SLIP OR FALL - WET SURFACE	
	<input type="checkbox"/> WALKING/RUNNING	<input type="checkbox"/> EXPLAIN: _____	<input type="checkbox"/> STRESS - Not Classified	<input type="checkbox"/> STRESS - RELATED TO SUPV/MGMNT
	<input type="checkbox"/> INHALATION/INGESTION		<input type="checkbox"/> CUMULATIVE TRAUMA - KEYBOARD RELATED	
	<input type="checkbox"/> TYPING/KEYBOARD	<input type="checkbox"/> OTHER: (SPECIFY) _____	<input type="checkbox"/> CUMULATIVE TRAUMA - UPPER EXTREMITY-NOT RELATED TO ABOVE	
<input type="checkbox"/> WRITING		<input type="checkbox"/> CUMULATIVE TRAUMA - LOWER EXTREMITY		
<input type="checkbox"/> DRAWING BLOOD		<input type="checkbox"/> CUT, SCRAPE OR PUNCTURE - MEDICAL SHARPS - CONTAMINATED		
<input type="checkbox"/> GIVING INJECTION		<input type="checkbox"/> CUT, SCRAPE OR PUNCTURE - MEDICAL SHARPS - NON-CONTAMINATED		
<input type="checkbox"/> REPETITIVE MOTION		<input type="checkbox"/> CUT, SCRAPE OR PUNCTURE - NON MEDICAL SHARPS		
<input type="checkbox"/> OTHER: (SPECIFY) _____		<input type="checkbox"/> OTHER: (SPECIFY) _____		

CONTRIBUTING FACTORS	WHAT WERE THE CONTRIBUTING FACTORS?			
	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> PHYSICAL DISABILITY	<input type="checkbox"/> LACK OF POLICY	<input type="checkbox"/> PROTECTIVE EQUIPMENT NOT USED
	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> ERGONOMIC PROBLEM	<input type="checkbox"/> INADEQUATE JOB TRAINING	<input type="checkbox"/> PROTECTIVE EQUIPMENT NOT AVAILABLE
	<input type="checkbox"/> INSTRUCTIONS NOT FOLLOWED		<input type="checkbox"/> UNSAFE STORAGE	<input type="checkbox"/> ASSISTIVE DEVICES NOT USED
	<input type="checkbox"/> INSTRUCTION / WARNING SIGNS DISREGARDED	<input type="checkbox"/> HORSEPLAY	<input type="checkbox"/> OTHER: (SPECIFY) _____	
	<input type="checkbox"/> BODY MECHANICS	<input type="checkbox"/> RUSHING		

EXPLAIN EXACTLY HOW THE INJURY/ILLNESS OCCURRED (DESCRIBE TERMS WHAT WHERE, WHEN AND WHY)

WHAT ACTION WILL BE OR HAS BEEN TAKEN TO PREVENT RECURRENCE. SEND DOCUMENTATION OF ANY WORK/SERVICE ORDER PURCHASE REQUISITION WITH THIS FORM TO EMPLOYEE HEALTH.

ACTIONS	<input type="checkbox"/> DEVELOP SAFETY PROCEDURE GUIDELINES	<input type="checkbox"/> PERSONAL PROTECTIVE EQUIPMENT ORDERED	<input type="checkbox"/> SAFETY TRAINING SCHEDULED
	<input type="checkbox"/> EQUIPMENT PLACED OUT OF SERVICE FOR REPAIRS	<input type="checkbox"/> REFERRED TO SAFETY FOR ASSISTANCE	<input type="checkbox"/> EMPLOYEE COUNSELED: _____ DATE _____
	<input type="checkbox"/> INDICATE WHC IS RESPONSIBLE AND BY WHAT DATE: _____	<input type="checkbox"/> ELIMINATED UNSAFE CONDITION	<input type="checkbox"/> OTHER: _____
	COMMENTS: _____		

MANAGER SIGNATURE: _____ INVESTIGATION COMPLETION DATE: _____

COMMENTS: _____