PRINT

# EMPLOYEE'S REPORT OF INJURY

TO BE COMPLETED FOR ALL WORK-RELATED INJURIES AND ILLNESSES

***All Boxes Must Be Filled in Order to Comply with State Regulations***

| | | | |
|---|---|---|---|
| Full Name: | | Today's Date: | |
| Home Address: | | Social Security Number: | |
| City, State, Zip: | | Date of Birth: | |
| Home Phone: | Work Phone: | Sex: | Marital Status |
| Job Title: | | Date of Injury: | |
| Department: | | Time of Injury: | |
| Who is your Supervisor?: | Supervisor's Title: | Supervisor's Phone: | |
| What job where you performing at the time of your injury? | | | |
| Where did the injury take place? | | | |
| In your own words, please explain what happened. (PLEASE BE SPECIFIC) | | | |
| What specific parts of your body were injured and what is the nature of your injury? | | | |
| Have you ever been under a doctor's Care the the same or similar injury? | | | |
| What machine, tool, or object was most closely connected with the injury, if applicable? | | | |
| Was this injury caused by someone or something outside the University? (Please explain) | | | |
| Names and phone numbers of witnesses: | | | |
| To whom did you report the injury? | | | |
| When did you report it? (If not immediately, please explain) | | | |

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|---|---|
| Employee Signature: | Date: |

**Fax to Human Resources at (314) 968-6909**