Employee Report Work-Related Injury/Illness

Employee: _____

Department: _____

Supervisor: _____

Work Schedule (circle): SUN MON TUES WED THURS FRI SAT

Shift Start Time: _____ Shift End Time: _____ Full Time? Y / N

Date of Hire: _____ Date of Birth: _____ Social: _____

Mailing Address: _____ Phone: _____

Incident Details	
Date of Accident:	Time of Accident:
Location:	
Nature of Injury:	
Part of body Injured:	
What were you doing that lead to your injury:	
What substance/object injured you, if any?	
Name of any witnesses to the incident:	
Was medical care provided at the scene? If so, what?	
Will you lose time for this incident (miss days/shifts)? If so, how many?	
Did you seek external medical treatment? If so, list doctor/hospital:	

Injuries must be reported immediately. Injuries reported after five days may not be approved by the Workers Compensation Board as valid claims. Return completed forms to the Office of Employee Engagement , 109 Getzville, Alumni House.

Employee Signature:_____Date:_____