**On-The-Job Injury/Illness Incident Report**

***(This form must be completed within 24 hours of injury/illness and submitted to the Human Resources Office)***

**Full Name of Injured Employee:** Click here to enter text.

**Address:**Click here to enter text.

**Date of Birth:** Click here to enter text. **Gender:** Male Female

**Department:** Click here to enter text. **Immediate Supervisor:** Click here to enter text.

**Date Hired:** Click here to enter text.

**Date of Accident/Injury:** Click here to enter text. **Time of Accident/Injury:** Click here to enter text.

**Time injured employee reported to work on the day of the incident:** Click here to enter text.

**Date Reported:** Click here to enter text. **Person to Whom Accident/Injury Reported:** Click here to enter text.

**Where did the accident/injury occur:** Click here to enter text.

**How did the accident/injury occur:** Click here to enter text.

**Did the injury/accident involve exposure to blood borne pathogens (bodily fluids)?  Yes  No**

**Was the injury witnessed?  Yes  No** If yes, name(s), address(es), phone number(s) of witness(es): Click here to enter text.

**List any tools, equipment, substances, machinery, etc. in use when the event occurred:**Click here to enter text.

**Describe the nature and severity of the injury. What part of the body was affected and how it was affected (i.e., strained back, chemical burn, hand, etc.)**Click here to enter text.

**What object or substance directly harmed the employee: (i.e., concrete floor, chlorine, radial arm saw):** Click here to enter text.

**What happened? Tell how the injury occurred (i.e., when ladder slipped on wet floor, employee fell 20 feet):** Click here to enter text.

**What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using (i.e., climbing a ladder while carrying materials):** Click here to enter text.

**Did the injured receive medical treatment?  Yes  No When?** Click here to enter text.

**If treatment was provided, state the name, address and phone number of the hospital or physician treating the individual (Attached copies of physician’s statement):** Click here to enter text.

**Was the injured transported to: Physician Hospital Ambulance Self Other**

**If transported by another person or ambulance, give name, address, and phone number of individual or list ambulance service:** Click here to enter text.

**Was an incident report filed with Campus Police? (If yes, attached copy of report) Yes No**

**Was the injured employee treated in an emergency room? Yes No**

**Was the injured employee hospitalized overnight as an in-patient? Yes No**

**How long was the injured employee off work due to the incident or will be off?** Click here to enter text.

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Name of person completing this form (please print) Signature**

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Relationship to Employee Date**

**On-the-job injury leave not to exceed 90 days.**

**Approved  Denied**

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Signature of President/Designee Date**