Employee Injury and Illness Report - Employee Form

Email report to injuryreport@listserv.miamioh.edu

Case No. ______
(To be completed by Safety Office)

Part 1 – Employee Idenfication (To be completed by employee)

1a. Name ______
1b. Home Mailing Address ______
2. Name of Employee's Supervisor ______

3. Department ______
Sub-Department ______
Campus (check applicable box) Oxford ☐ MUH ☐ MUM ☐ VOA ☐
4. Work Phone ______
5. Hire Date ______
Time at Present Position ______

6. Unique ID or Banner ID No. ______
7. Birth Date ______
8. Gender ______
9. Job Title ______

10a..Occur on University Business? Yes ☐ No ☐
10b.. Occur on University Property? Yes ☐ No ☐
10c.. Name of Specific Location/Building: ______

Part 2 – Injury or Illness Information (To be completed by employee)

11. Date of incident: ______ 12. Time: ______ AM ☐ PM ☐ 12b. Date & Time reported to Supervisor ______

13. Time Employee Began Work: ______ AM ☐ PM ☐ 14. Were you wearing/using safety equipment at the time of the injury/illness? Yes ☐ No ☐

15. **Describe the injury & body part(s) affected:** Be specific. (Examples: laceration to right index finger, contusion to left knee, sprain to right ankle.)

______

16. **What were you doing, how did injury occur?** Be specific. (Examples: carrying tools up a ladder when the ladder slipped on wet floor and worker fell 20 feet.)

______

17. **What object or substance directly harmed the employee?** Be specific. (Examples: concrete floor, utility knife, radial arm saw.) Leave blank if does not apply.

______

18 Witnesses: Yes ☐ No ☐ if yes:

(1) ______ Name ______ Dept. Phone

(2) ______ Name ______ Dept. Phone

Did You Seek Medical Treatment? No ☐ Yes ☐ (If yes, please have health care provider complete details below.)

Part 3 – To Be Completed by Health Care Provider:

Name of facility: McCullough-Hyde Memorial Hospital: ☐ Miami Health Services Center: ☐ Other: ______

Did the injury lead to lost work days starting the day after the accident? ☐ No ☐ Yes If Yes, Total # Lost Work Days: ______ Date Returned to Work: ______

Did the injury lead to restriction of motion or work? ☐ No ☐ Yes If Yes, Total # of days of restriction motion/work: ______

Alcohol/Drug Screen Administered: Yes ☐ No ☐

Medical Treatment Provided (check type of treatment): ☐ First Aid Only ☐ Treatment Beyond First Aid (Please describe below)

______

Health Care Provider Signature: ______ Date/Time of Treatment: ______

To Submit Form:

1) Employee completes and prints form.
2) Read and check the statement (below)
3) Health Care Provider completes part 3
4) Employee and supervisor sign form.
5) Scan form to PDF and email toinjuryreport@listserv.miamioh.edu

Employee's Signature ______ Date ______

Supervisor's Signature ______ Date ______

Supervisor's Statement (optional) is attached: ☐ Yes ☐ No

☐ By checking this box, I affirm that I have read and understood all of the above and this report is accurate to the best of my knowledge.