Employee Injury and Illness Report - Employee Form

Email report to *injuryreport@listserv.miamioh.edu*

Print form

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

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

Classification (check one) ☐ AFSCME ☐ SATSS ☐ FOP/MUPD ☐ Faculty ☐ Unclassified

Name | **Home Mailing Address** | **Name of Employee's Supervisor**

Department | **Sub-Department** | **Campus (check applicable box)** ☐ Oxford ☐ MUH ☐ MUM ☐ VOA | **Work Phone** | **Home Phone** | **Birth Date**

Unique ID or Banner ID No. | **Gender** | **Job Title** | **Hire Date** | **Time in current position**

Occur on University Business? ☐ Yes ☐ No
Occur on University Property? ☐ Yes ☐ No
Name of Specific Location/Building:

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

Date of incident: | **Time:** ☐ AM ☐ PM | **Date & Time reported to Supervisor**

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

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

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.)

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

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.)**

☐ **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.**

Employee's Signature _____ **Date**

Supervisor's Signature _____ **Date**

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

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:**