



Employee Report of Injury

Date of Injury: _____

Date of Report: _____

Personal Information

Employee Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: (____) _____

Date of Birth: _____

Please circle: MARRIED SINGLE

Number of Dependents: _____

Please circle: MALE FEMALE

Date of Hire: _____

Please circle: FULL-TIME PART-TIME

Department: _____

Job title: _____

of Days Regularly worked in a week _____

Accident Information

Time workday began: _____ AM PM

Time injury occurred: _____ AM PM

Injury Location: _____

Did you leave campus? YES NO

If so, what date did you return? _____

Did you receive first aid? YES NO

From whom: _____

Did you see a doctor? YES NO

Who? _____

Were you taken to the hospital? YES NO

By whom: _____

Was parent/guardian/family notified? YES NO

Describe the nature of the injury (ex. Burn, cut, fracture)

Part(s) of the body directly affected by the injury or illness (ex. Hand, arm, circulatory system)

Describe the events that caused the injury (ex. Fell, operating machinery, chemical exposure)

Name the object or substance which directly injured you (ex. Knife, floor, acid, oil)

Property Damage Information

Describe any property damaged (including vehicle and/or equipment description and identification # (s):

Witness Information

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: () _____

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: () _____

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: () _____

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: () _____

Signatures

Signature of injured employee _____ Date: _____
Signature of person reporting injury _____ Date: _____
Signature of Supervisor _____ Date: _____
Signature of Dean _____ Date: _____

NOTE: Signed copies of Report of Injury must be sent to:
1.) Barb Farrell, Operations Office, Hawkeye Ctr.
2.) Appropriate Director/Dean