



**First Report of Injury or Illness**

Regardless if medical treatment was obtained, this report must be returned within 24 hours of injury/illness to: **Environmental Health and Safety**, 414 JM Smith Hall

You may submit the file using the button at the bottom of the second page.

**Section I: Information about the injured person**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

UID \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Student \_\_\_\_\_ Visitor \_\_\_\_\_ Employee \_\_\_\_\_

(Student workers select EMPLOYEE and list STUDENT WORKER as job title; if employee or student worker, please complete ALL employee information.)

**Section II: Employee Information**

Job Title \_\_\_\_\_

Department \_\_\_\_\_

Building \_\_\_\_\_ Hire Date \_\_\_\_\_

Supervisor Name \_\_\_\_\_

Supervisor Title \_\_\_\_\_

Supervisor Phone \_\_\_\_\_

Employee Status

Full-time

Part-time

Contract

N/A

**Section III: Information about the accident**

Date injury occurred \_\_\_\_\_ Date Employer notified of injury \_\_\_\_\_

Location of accident (closest building) \_\_\_\_\_

Specific location (examples: Room #, hallway, stairwell, parking lot) \_\_\_\_\_

Time employee began work \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Time incident occurred \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Number of days away from work (do not count the day the injury occurred)\* \_\_\_\_\_

Number of days of restricted work activity\* \_\_\_\_\_

Date employer notified of lost work time

\_\_\_\_\_

**Section IV: Information about the physician or other health care professional**

If treatment was given away from the accident location, provide the name and address of the medical facility

Facility Name \_\_\_\_\_

Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Doctor or Physician \_\_\_\_\_

Was the employee treated in an emergency room? Yes No

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

\*If the injured person misses work or requires restricted work activity due to this injury/illness after this report is submitted, please contact Environmental Health & Safety in 414 JM Smith Hall, 678-5700, and Employee Benefits in 165 Administration Building, 678-3573.



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### Section V: Details about the accident

What was the injured person doing immediately before the incident occurred? Describe the activity, as well as the tools, equipment, or material(s) being used. Be as specific as possible. Examples: "climbing a ladder while carrying roofing materials;" "spraying chlorine from a hand sprayer;" "daily computer key-entry."

Describe the incident. How did the injury occur? Examples: "When the ladder slipped on the wet floor, the worker fell 20 feet;" "Worker was sprayed with chlorine when a gasket broke during replacement."

What was the injury/illness? Be specific, including the body part affected and how. "Hurt," "pain," "sore," ... are NOT specific enough. Examples: "Strained lower back;" "Chemical burn to right hand;" "Carpal tunnel syndrome affecting left wrist."

What object or substance directly harmed the individual? Examples: "Concrete floor;" "Chlorine;" "Radial arm saw."

What has been done to prevent the same or similar accident from recurring?

### Section VI: Signatures

Injured Person \_\_\_\_\_ Date \_\_\_\_\_

Supervisor \_\_\_\_\_ Date \_\_\_\_\_

This form contains information relating to employee health and must be used in a manner that protects the confidentiality of the employee to the extent possible while the information is being used for occupational safety and health purposes.

### Section VII: For Environmental Health & Safety Use

OSHA Case Number \_\_\_\_\_ Date of follow-up with injured person \_\_\_\_\_

Notes