THE UNIVERSITY OF MEMPHIS

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

Updated: Jan 2019

Click to Submit to EH&S