INJURY / ILLNESS @ WORK REPORT

ALL QUESTIONS MUST BE ANSWERED

Check One Employee ☐ Student ☐ WIOA Participant ☐

Please type or print and return to the Office of Human Resources within 5 days from date of injury

Name				Today's Date			
Address				Married	Single	Widowed	Divorced
City		State	Zip		Phone #		
SS# (REQUIRED)		Birthdate		Date of Hire			
Date of Injury	Time of Injury	Job Title	Normal Work Hours Example: 8am-6pm M-T	Time began work on date of injury	# Work Days Lost		
Date returned to work			Place where injury occurred				
Date notified College			Date treated by Physician				
Attending Physician/Address					Phone #		
Hospital					Date hospitalized		
Nature of Injury							
Part of body injured	Left	Right	Both	Type of Injury: (Cut, Bruise, etc.)			
State how injury occurred							
Witnesses							
If injury was caused by another person not in our employ, give name and address:							
Remarks							
SIGNATURE OF INDIVIDUAL INJURED							
SIGNATURE OF EMPLOYEE'S SUPERVISOR					DATE		