

Completion of this form is required for work related injuries of more than first aid. The PI, Manager, Supervisor, or Faculty member is to conduct a preliminary investigation, then complete this form and submit it to the Disability & Leave Administration Unit, Human Resources, within 3 days of the injury.

Employee Information

Employee Name: _____ UID #: _____
Employee's Job Title: _____
Employee's Home Dept.: _____

Injury Information

Date of Injury: _____ Time of Injury: _____ Location of Injury: _____
Date Reported: _____ Reported to: _____
What task was the employee performing when the injury occurred? _____
How did the injury occur (describe in detail, provide all factors contributing to the injury): _____
List body part(s) injured: _____
Was another person involved in the accident, list name(s) and describe how they were involved: _____
Were there any witnesses, if yes list names: _____
Was there anything unusual about the accident? _____
Was the employee acting in the course of employment? Yes _____ No _____ Unsure _____
Did the employee receive medical treatment? Yes _____ No _____ Unsure _____
Has the employee returned to work? Yes _____ No _____ Unsure _____

Corrective Action

Was the incident discussed with the employee? Yes _____ No _____
How could this incident/injury be prevented in the future? _____
Corrective action to be taken by the Department: _____

Sign off

PI/Mgr/Spvsr/Faculty/Adm (please print) _____ Date _____
Signature _____

Date received by Disability & Leave Administration:

cc: Insurance Carrier
Claims Administrator
Safety Department