



Work Related Injury Report Form
SUPERVISOR REPORT OF EMPLOYEE INJURY

Employee Name: _____ Employee ID # _____

Department: _____

Classification: _____

Work Phone # of Supervisor: _____

Date of Hire: _____ Gender: _____ Marital Status: _____

Number of Days Per Week Worked: _____ Normal Days Off: _____

Number of Hours Worked Per Day: _____ Current Hourly Rate of Pay: \$ _____

Normal Starting Time of Employee: _____ Normal Ending Time of Employee: _____

Date of Injury: _____ Time: _____

Date & Time Injury Reported to You: _____

Has the Employee Lost Any Work Time Due to the Injury: _____

If Yes, what was the first day (other than the date of the accident that the employee missed work due to the accident: _____

Has the employee returned to work: _____ If yes, when? _____

Did the injury happen on campus? _____ If not give exact location including street address, city, county and state: _____

Who Witnessed the Accident: _____

What was the employee doing when injured? Be specific:

How did this injury occur? Be Specific?

Did the injury occur because of a mechanical defect? _____

Did the injury occur because of an unsafe act? _____

If yes to either of the above questions explain in detail:

What Part(s) of the employee's body were injured?

Signature of supervisor: _____

Supervisor's Title: _____

Date: _____

This form should be completed and returned to Human Resources (Ann Hargenrader) as soon as possible but no later than 48 hours following the accident.

FOR HUMAN RESOURCES OFFICE USE ONLY

Date Form Provided To Supervisor: _____

Form Provided to Employee _____ Sent to Supervisor _____

Date Form Returned to Human Resources: _____ To: _____