

## WORKPLACE INJURY/WORKPLACE ILLNESS REPORT FORM

This is page ONE of a two-page form. Please complete both pages as appropriate.

This form is used to report a workplace injury or workplace illness. This form is to be completed and submitted to Human Resources & Employee Development at the address at the top of this form within **24 hours** of the injury or illness. Please type or print legibly.

Name of Division											
Assigned Unit/Department											
Injured Employee's Name											
Social Security Number					MCTC ID Number						
Job Title											
Employee's Date of Original Hire					Date of Birth						
Date Started in Above Job Title					Marital Status			S	M	W	D
Employee's Home Address											
Employee's Home Phone Number											
Employee's Status	Regular-Status				Temporary			Student Employee			
	Full-Time				Part-Time						
Date of injury/Date Illness began					Time of injury/Time illness began						
Time began work on date of injury											
Did injury/illness occur on participating organization's property?					Yes			No			
Location where the injury/illness occurred (building, intersection, etc.)											
Did employee lose any time from work?	Yes	No	If yes, how much?								
Date and time returned to work											
Regular work schedule											
Did injury/illness involve time away from work beyond the date of injury/onset of illness?					Yes			No			
Did employee receive medical attention?					Yes			No			
Describe type of treatment received.											
Time/Date Returned to Work											

PLEASE GO ON TO PAGE TWO.

## WORKPLACE INJURY/WORKPLACE ILLNESS REPORT FORM

This is page TWO of a two-page form. Please complete both pages as appropriate.

Name of hospital/physician providing medical attention.				
Describe the exact body part(s) affected and the type of injury/illness sustained to each. (i.e., left hand – cut, broken; right leg – strained, pulled muscle, etc.)				
Has employee sustained previous injury or previous illness affecting same body parts?		Yes		No
Describe how the injury occurred/how the illness developed.				
Describe any equipment/materials being used at time of injury/illness.				
Enter names and telephone numbers/e-mail address of any witnesses to injury/illness.				
Name		Telephone/E-mail		
Name		Telephone/E-mail		
Name		Telephone/E-mail		
Supervisor's name				
Supervisor's telephone				
Supervisor's e-mail				
Does supervisor have any reason to question this injury/illness?		Yes		No
If "Yes" to above question, do not enter any comments. A separate written statement from supervisor is required.				
Supervisor's signature		Date		
Employee's signature		Date		

**COPIES AND DISTRIBUTION:** Original to Human Resources & Employee Development; one copy to employee; one copy to supervisor.

FOR HUMAN RESOURCES & EMPLOYEE DEVELOPMENT USE ONLY

--