

Workers' Compensation Employee Incident Report: Work Related Accidents Only

[PLEASE FILL OUT COMPLETELY]

Today's Date:

Date of Injury:

Name

Birthdate:

SSN:

Marital Status:

Address:

Home Phone:

City, Zip:

Hire Date:

Where Injury Occurred

Time of Day:

On University Premises: Yes No

Doing Regular Duties: Yes No

How Did Injury Occur:

What Part of Body was Injured:

Describe Injury:

Witness (Name and phone):

Name of Supervisor:

Phone Number:

Date Supervisor Notified of Injury:

Treating Physician:

Phone Number:

Address:

First Treatment Date:

First Day Off Work:

Return to Work Date:

Employee Signature:

Employee Job Title:

University Department/Area:

*****EMPLOYEE RETURN THIS COMPLETED FORM TO YOUR SUPERVISOR AS SOON AS POSSIBLE*****

Supervisor Signature:

Date:

*****Supervisor and/or Dept. Payroll Staff Must Complete the Following*****

Employee's Job Class Code:

Department Code:

Rate Per Hour:

Hours Worked Per Day:

Days Per Week:

Comments:

*****REPORTS INVOLVING LOST TIME SHOULD BE FAX'D TO 612-624-6070*****

*****OTHER REPORTS MAY BE SENT BY CAMPUS MAIL TO WORKERS' COMPENSATION*****

633 WBOB 1300 S 2nd Street PHONE: 624-6054/624-6019