FAIRMONT STATE UNIVERSITY / PIERPONT COMMUNITY AND TECHNICAL COLLEGE

OCCUPATIONAL INJURY/ILLNESS/INCIDENT REPORT

Use this form for EMPLOYEES ONLY (faculty, staff and student workers for work-related reports)

In order for all claims to be filed correctly, this form must be filled out completely and accurately within 24 hours of injury.

Please contact Cindy Curry at x4386 or Elizabeth McCutcheon at x4383 prior to placing this form in campus mail.

Date Reported: _____ Date of Birth: _____

Name of Injured: _____ Title: _____

Social Security Number: _____ Home Telephone # _____

Department/School: _____ Email Address: _____

INJURY/ILLNESS/INCIDENT DETAILS:

Date of Injury: _____ Time of Injury: _____ ☐ a.m. ☐ p.m.

Time Began Work on Date of Injury: _____ ☐ a.m. ☐ p.m.

Stopped Work for Injury (if applicable): Date: _____ Time: _____ ☐ a.m. ☐ p.m.

COMPLETE ONE: Date Returned to Work: _____ ***OR*** ☐ No Time Lost

Name(s) of any witnesses to injury/illness: _____

Name of person reporting injury/illness: _____

Occupational Injury/Illness Report prepared by: _____

ACTIVITY PRIOR TO INJURY / ILLNESS/INCIDENT:

Exact location of accident: _____

What was employee doing prior to accident? _____

How did accident occur? _____

Describe any equipment / materials being used at time of injury/illness: _____

Was there a malfunction in the equipment? ☐ No ☐ Yes, explain _____

What unsafe acts or conditions (if any) contributed to this accident? _____

Was safety equipment provided? ☐ N/A ☐ No ☐ Yes

MEDICAL:

Nature and extent of known injuries. Please be specific: _____

Has first aid been rendered to the employee? ☐ No ☐ Yes

If yes, please describe: _____

Have medical services been rendered to the employee? ☐ No ☐ Yes

If yes, list names and addresses of all doctors, hospitals, medics or other medical personnel consulted:

If medical services were sought at a later date, explain: _____

SUPERVISOR'S RECOMMENDATIONS:

Recommend a permanent solution: _____

SUPERVISOR'S NAME: *(Please print legibly)* _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ CASE NUMBER: _____

Revised 1/2019