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 email this form to Ashley.Maxey@fairmontstate.edu and EHS@fairmontstate.edu
Please contact Ashley Maxey at 304-367-4113 if you have any questions.

Date Reported:_____ Date of Birth:_____
Name of Injured:_____ Title:_____
Hire Date: _____
Home Address: _____ Gender: ___Male ___Female ___Not Listed
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: _____

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:_____
_____
Describe any object or substance that contributed to the 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:
_____
Was there an overnight hospitalization? ☐ No ☐ Yes
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:_____