

Employee First Report of Injury

**The injured employee must complete this form, not his/her supervisor.

Date of Incident: _____ **Date Reported:** _____ **Reported To?** _____

If date reported is greater than two days, please explain the reason for the lag time:

Employee Information

Last Name _____ First Name _____ M.I. _____
 Address _____ City _____ State _____ Zip _____
 Telephone Number () _____ Date of Birth _____ Date of Hire _____
 Social Security# _____ Marital Status Single Married Other
 Occupation _____ Full Time Part Time
 Male Female Banner ID # _____ Department: _____

Wage Information

Number of days worked per week _____ Number of hours per day _____ Wage \$ _____ Hour/Annual

Accident Information (Be specific; include building, indoor/outdoor, side of building, room number, etc.)

Accident Location _____
 Time of Injury : am pm Time work began : am pm
 Returned to work date _____ Last day worked _____
 Name of person notified _____ Telephone () - _____

Witness Information

Name	Relation	Phone Number
Address	City	State Zip

Provide a detailed description of how the accident/injury occurred (include what you were doing at the time of the injury, conditions, equipment being used, were you wearing PPE, cause, specific location, etc.)

What body part(s) is injured? _____ Left Right N/A
 Yes No

***Required information: Did you/do you plan to go to the doctor?**

Where did you seek treatment? _____

Employee Signature: _____ Date: _____

Please return completed form to your supervisor, or fax to Risk Management at 303-871-4455