Employee Report of Injury

The injured employee must complete this form, not the employee's supervisor.

UNIVERSITY OF DENVER

Date of Incident _____/_____/_____ Date Reported _____/_____/_____

Time of Injury: ____:____ ☐AM ☐PM Time shift began ____:____ ☐AM ☐PM

Reported to? _____

Did you receive the Workers' Compensation Medical Providers list? ☐Yes ☐No

If there was a delay in reporting the injury, please explain the reason for the delay: _____

_____

REQUIRED: Your regular work schedule. Please enter number of hours on each day, or the time your shift starts & ends:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Weekly **Total** Hours

If you work an overnight shift, please document that shift's hours on the day of the week that the shift starts.

Personal Information

Full Name _____ Date of Birth ____/____/_____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Number _____ Gender: ☐Male ☐Female ☐Non-binary

DU ID # 87_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Other

Job Title _____ ☐Full Time ☐Part-time Date of Hire _____/_____/_____

Department _____ Preferred language: _____

If you are an unpaid intern/practicum, what is the DU program/school you are enrolled in: _____

Accident Information Be specific. Include the building, indoor/outdoor, side of building, room number, etc.

Accident Location _____

Did you finish your shift on the day you were injured? ☐Yes ☐No

Any Witnesses?

Name(s) _____ Relation _____ Phone Number(s)_____

Provide a detailed description of how the injury occurred. Attach additional pages if needed. Include what you were doing, conditions, equipment being used, if you wore PPE, suspected cause, specific location, etc.

Body part(s) injured: _____ ☐Left ☐Right ☐N/A

Did you/do you plan to go to the doctor? ☐Yes ☐No Where? _____

If you want your medical costs to be covered by workers' compensation insurance, you must seek treatment at a provider listed on the Workers' Compensation Medical Providers list.

Employee Signature: _____ Date: _____/_____/_____

Return this completed form and a signed copy of the Workers' Compensation Medical Providers list to your supervisor. If your supervisor is unavailable, please email these forms directly to risk@du.edu. Do not scan forms directly to ERM. Please scan all forms to yourself and then forward the email to risk@du.edu. If you want to encrypt the email, please put "DU Confidential" in the subject line. If you have any concerns or want to discuss any of the above questions, please contact risk@du.edu or 303-871-2555.