UNIVERSITY of DENVER
Enterprise Risk Management

Employee First Report of Injury

The injured employee must complete this form

Information can be typed into form but cannot be saved

Date of Incident _____/_____/_____ Date Reported _____/_____/_____
Reported to? _____
Did you receive the provider letter from your supervisor? ☐ Yes ☐No

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

Required information: Did you/do you plan to go to the doctor? ☐ Yes ☐ No
Last Name _____ First Name _____M.I._____
Address _____ City _____ State _____ Zip _____
Home Telephone Number _____
Social Security# (please provide): _____-____-_____ Date of Birth: _____/_____/_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Partnered
Occupation _____ ☐Full Time ☐ Part-time
Date of Hire: _____/_____/_____ Department: _____
☐Male ☐ Female DU (Banner) ID#: _____

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

Accident Information (Be specific; building, indoor/outdoor, side of building, room number, etc...)
Accident Location _____
Time of Injury: ____:____ ☐ AM ☐PM Time work began ____:____ ☐ AM ☐PM

Last day worked _____/_____/_____ Returned to work date _____/_____/_____

Name of person notified _____ Phone Number _____

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? Please use "Tab" to move between lines.)
_____
_____
_____
_____
_____.
What body part(s) is injured? _____ ☐Left ☐Right ☐N/A
Where did or will you seek treatment? _____

Employee Signature: _____ Date: _____/_____/_____

Please PRINT, SIGN, and RETURN completed form to your supervisor to be faxed or emailed to
Enterprise Risk Management at:
303-871-4455 -or- risk@du.edu