**Employee Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male: \_\_\_\_ Female:

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Married: \_\_\_\_ Single:

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip:

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #:

Social Security Number: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Age:

Department in which regularly employed:

Job Classification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hire Date:\_\_\_\_\_\_\_\_ Hours work per day: \_\_\_\_\_\_ # of days/week: \_\_\_\_

Was another person responsible? \_\_\_\_ Yes \_\_\_\_No

**Witnesses: (Attach written Statements)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On date of injury time started work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time work ended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Injury / Illness Information**

Date of Injury / Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Day: \_\_\_\_ AM/PM

Where did injury occur? (Specific Location):

What was the employee doing when injury/illness occurred? (Be specific. Tell what and how it happened):

Object or substance that directly injured the employee:   
Part of body affected. (Be Specific: Right hand-Left hand?):

I have verified the employee was at work at date and time of incident as stated above. \_\_\_Yes \_\_\_No

Do facts indicate the injury happened at work? \_\_\_ Yes \_\_\_ No

Did injury/illness cause absence from work \_\_\_ Yes \_\_\_ No

Has employee returned to work? \_\_\_ Yes \_\_\_ No

Date returned to work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Safety Information**

An unsafe condition existed (check all that apply): An unsafe act resulted from (check all that apply):

\_\_\_\_ Defective equipment/tools \_\_\_\_ Lack of skill/training \_\_\_\_\_ Not following safety rules

\_\_\_\_ Poor housekeeping \_\_\_\_ Inattention \_\_\_\_\_ Inadequate planning

\_\_\_\_ Poor working conditions (lights) \_\_\_\_ Unsafe act/horseplay \_\_\_\_\_ Improper work method

\_\_\_\_ Slippery/uneven walking surface \_\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Chemicals (Include MSDS)

***Treatment and Filing Claim (check one):***

 I choose to accept a medical evaluation for treatment and file a claim for the above noted condition and will go to the appropriate medical facility University Enterprises, Inc. has designated.

 I chose to decline the medical evaluation for treatment and filing a claim for the above noted condition. I understand that I do have one year from the date of injury to file a Workers’ Compensation Claim and by signing this document, I also understand that should I decide to seek medical treatment for this injury, I must immediately notify my supervisor and go to the medical facility University Enterprises, Inc. has designated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature Date