



OCCUPATIONAL INJURY/ILLNESS REPORT
(For guidance on how to complete this form, see Wright Way Policy 6032)

RETURN TO: Dept. of Env. Health & Safety, 129 Allyn Hall
Office: 775-2215 // Fax: 775-3761

NOTE: FORM MUST BE COMPLETED BY EMPLOYEE'S SUPERVISOR/ CHAIR/ DIRECTOR

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes

Information about the employee: (Mandated by OSHA for reporting purposes only)

- 1. Name:
2. Date of Birth: ___/___/___ 3. Sex: Male [] Female [] 4. Employee [] Student Employee []
5. Department:
6. Campus Address (Room/Bldg): 7. Work No. 8. Date Hired: ___/___/___

Information about the incident:

- 9. Date and time of injury: ___/___/___ AM / PM [] Check if time cannot be determined
10. Time began work: AM / PM 11. Was the incident on employer's premises? Yes [] No []

12. Place of incident (If accident or exposure occurred on employer's premises, give address of plant or establishment in which it occurred. Do not indicate department or division within the plant or establishment. If accident occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number, please provide place references locating the place of injury as accurately as possible.

13. What was the employee doing before the incident occurred? (Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing material"; "spraying chlorine from hand sprayer"; "daily computer key-entry")

14. What happened? (Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was spraying chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time"). Use a separate sheet for additional space.)

15. What was the injury or illness? (Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back"; "chemical burn on right hand"; "carpal tunnel syndrome"):

16. What object or substance which directly harmed the employee (Example: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.)

17. If the employee died, when did death occur? Date of Death: ___/___/___

18. Lost work time: Yes [] No [] Restricted work time: Yes [] No []

Signature of Supervisor: Date:

Printed Name of Supervisor:

Official Title/Position of Supervisor:

Address (Room/Bldg.): Work No.:

Information about the physician or health care professional

19. Degree of Treatment: No Treatment Required [] First Aid Only [] ER/Urgent Care [] In-Patient Hospitalization []

20. Name of physician or health care professional:

21. Street City State Zip:

FOR EHS USE ONLY CASE/FILE NO.:

Recordable [] Non-Recordable [] No. of Lost Work Days No. of Restricted Work Days