FILE WITHIN 5 DAYS OF INCIDENT. (In the event of a serious or fatal injury or illness, notify within 24 hours. It is the supervisor's responsibility to report lost time due to an occupational injury or disease. Failure to do so immediately may result in departmental fines. NOTE: PLEASE FILL IN EACH BLANK)

OCCUPATIONAL ACCIDENT OR ILLNESS REPORT

Name _____ SSN _____

Address _____ Zip _____

Home Phone (___) _____ Sex ___ Date of Birth _____

Marital Status _____ No. of Children Under 18 ____ Date of Hire _____

Department (Name)_____ Budget Code _____ Title Code_____

Date of Injury

☐ ☐

_____ Time Returned to Work _____

Date Employer Knew _____Supervisor _____

Mech Defect? Y ☐ N ☐ Same Wage? Y ☐ N ☐ Empl Premises? Y ☐ N ☐

Work Phone Number _____ Unsafe Act? Y ☐ N ☐ Hourly Salary $_____

Exact Location of Injury (Building, etc.) _____

Nature of Injury or Illness _____

Physician and Address _____

Diagnosis: _____ Diagnosis Date:_____

How Did Injury Occur? _____

☐ N ☐

SEND COPIES TO: