

WORKPLACE INJURY/ ILLNESS REPORT FORM

This is page ONE of a two-page form. Please complete both pages as appropriate.

This form is used to report a workplace injury or workplace illness. This form is to be completed and submitted to the Safety & Health Department within **24 hours** of the injury or illness. The form is available on the Safety & Health website at <http://www.marshall.edu/safety/files/HR-SERV-FORM-31.pdf> as an Adobe® form with fields that can be completed and submitted online. Please print a paper copy of this form for your records. This form will transmit electronically to the appropriate parties for processing.

Name of Organization															
Assigned Unit/Department															
Injured Employee's Name															
MU ID Number															
Job Title															
Employee's Date of Original Hire				Date of Birth											
Date Started in Above Job Title				Marital Status					S		M		W		D
Employee's Home Address															
Employee's Home Phone Number															
Employee's Status		Regular-Status				Temporary				Student Employee					
		Full-Time				Part-Time									
Date of injury/Date Illness began				Time of injury/Time illness began											
Time began work on date of injury															
Did injury/illness occur on participating organization's property?								Yes				No			
Location where the injury/illness occurred (building, intersection, etc.)															
Did employee lose any time from work?		Yes			No		If yes, how much?								
Date and time returned to work															
Regular work schedule															
Did injury/illness involve time away from work beyond the date of injury/onset of illness?								Yes				No			
Did employee receive medical attention?								Yes				No			
Describe type of treatment received.															
Time/Date Returned to Work															

PLEASE GO ON TO PAGE TWO.

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This is page TWO of a two-page form. Please complete both pages as appropriate.

Name of hospital/physician providing medical attention.			
Describe the exact body part(s) affected and the type of injury/illness sustained to each. (i.e., left hand – cut, broken; right leg – strained, pulled muscle, etc.)			
Has employee sustained previous injury or previous illness affecting same body parts?		Yes	No
Describe how the injury occurred/how the illness developed.			
Describe any equipment/materials being used at time of injury/illness.			
Enter names and telephone numbers/e-mail address of any witnesses to injury/illness.			
Name		Telephone/E-mail	
Name		Telephone/E-mail	
Name		Telephone/E-mail	
Supervisor's name			
Supervisor's telephone			
Supervisor's e-mail			
Does supervisor have any reason to question this injury/illness?		Yes	No
If "Yes" to above question, do not enter any comments. A separate written statement from supervisor is required.			
Supervisor's signature		Date	
Employee's signature		Date	

COPIES AND DISTRIBUTION: Original to Safety & Health; one copy to employee; one copy to supervisor

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