Marshall University Safety& Health
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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.

WORKPLACE INJURY/WORKPLACE ILLNESS REPORT FORM

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

FOR HUMAN RESOURCE SERVICES USE ONLY

THIS FORM IS PRODUCED BY MARSHALL UNIVERSITY SAFETY & HEALTH. IF PROBLEMS ARE ENCOUNTERED WITH THE USE OF THIS FORM OR IF THE USER HAS ANY SUGGESTIONS FOR IMPROVEMENTS TO THIS FORM, PLEASE CONTACT SAFETY & HEALTH AT THE ADDRESS SHOWN AT THE TOP OF THIS FORM.

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Click to Submit Completed Form