

Lawrence University
EMPLOYEE ACCIDENT/INJURY INCIDENT REPORT

This form should be completed and submitted to Human Resources within 24 hours from the time of occurrence (or by the end of the shift on the day of the occurrence) for all work-related injuries/illnesses. Even minor injuries should be reported as they may develop into something more serious. A delay in submission of this report or the omission of information on this report could result in a delay or denial of benefits.

Completed by: _____ Title _____

Phone: _____ Date: _____

Employee name _____ Date/time of Injury _____ AM ___ PM ___
(LAST, first, middle initial)

Department _____ Occupation _____ Supervisor _____ Ext # _____

SS# _____ Date of Birth _____
(Month, day, year)

Home address: _____
(Street, City, Zip)

Date Hired: _____ Telephone: _____

Male _____ Female _____ Time employee began work _____ AM ___ PM ___

INJURY DESCRIPTION

What was the employee doing just before the incident occurred? Be specific.

What happened? Explain how the injury occurred. _____

What was the body part injured? _____

Location where injury occurred _____
(include building & address)

Any equipment, material, or chemicals employee was using: _____

Malfunction _____ yes _____ no Explain _____

Witness _____

MEDICAL TREATMENT:

If medical treatment is received at a later date, you must notify Human Resources at ext.6543 as soon as possible.

Did you see the on-campus nurse? _____ Yes _____ No

DID YOU SEE A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL? _____ Yes _____ No

If yes, Physician name or Facility name: _____

Address _____

Was emergency transportation required? _____ yes _____ no

Was employee treated in an emergency room? _____ yes _____ no

Was employee hospitalized overnight as an in-patient? _____ yes _____ no

If the employee died, when did death occur? Date of death: _____

Employee Signature _____ Supervisor Signature _____

PLEASE COMPLETE & RETURN TO HUMAN RESOURCES Case # from log: _____