Employee Injury/Incident Report

Personal Data

Name: _____ Today's Date: _____

Date of Birth: _____ Social Security #: _____

Address: _____ Home Phone #: _____

City: _____ Work Phone #: _____

State: _____ Zip Code: _____

Department Information

Department: _____

Title: _____

Supervisor's Name: _____

Employment Status

Date of Hire: _____

Supervisor notified? _____

Work Phone #: _____

Campus Location

Campus: _____ Building: _____ Room: _____

Injury/Incident

Date of Injury: _____ Time of Injury: _____

Describe the nature and extent of injury or incident being reported.

Describe the activity being performed when the injury or incident occurred.

What object/substance directly contributed to the injury? (Fall/trip/lifting/carrying/pushing/pulling; machine, vapor inhaled; chemical/irritant to skin, etc.)

How could this injury or incident have been prevented?

What Personal Protective Equipment was provided?

Was it being used correctly? Yes No

Witness(es) Provide name, title, phone#.

Name: _____ Title: _____ Phone#: _____

Name: _____ Title: _____ Phone#: _____

Medical Treatment

Please select one:

☐ Basic First Aid

☐ Hospital / ER

☐ Doctor / Clinic

☐ None

Employee Signature

_____ _____

Signature Date

Please submit completed form to Risk Management, located in Building 155, Room B106, no later than one (1) business day after the injury/incident. Inquiries may be directed to Risk Management at 254-526-1347 or 1-800-492-3348 ext. 1347.