

WARTBURG COLLEGE WORK-RELATED INJURY REPORT FORM

This report must be completed whenever an incident occurs resulting in an injury to an employee. This report is to be completed by the Supervisor or Department Chair and the injured Employee by the end of the shift during which the injury occurred and forwarded to Human Resources Office, LH 203. (In the event no supervisor is immediately available, the next business day.)

Name of Employee involved _____ ID # _____

Home Address _____ Phone _____

Regular Employee _____ Student Employee _____ H.S. Student Employee _____

Date of Birth: _____ Gender _____ Marital Status _____ No. of Dependents _____

Date of Incident: _____ Time: _____ Time employee began work: _____

Location of Incident: _____

Describe nature of the injury and part of body directly affected: (Example: Sprained right ankle)

Describe exactly the activity taking place at the time of injury and how the injury occurred (use separate sheet if necessary):

Name & phone of witnesses _____

Will this injury involve missed work time? ____ Yes ____ No _____ May involve lost time

MEDICAL SERVICES

If medical treatment is necessary, designated providers are Allen Occupational Health, Noah Campus Health Clinic, and Waverly Health Center. Follow-up appointments must be scheduled with Allen Occupational Health. You may call Terri Meier at 8521 for assistance with appointments.

Medical Treatment (circle one) Yes No

If Yes, name of attending physician: _____

Name and address of facility where treatment was rendered: _____

Employee Signature

Date

Time

Department Chair/Supervisor Signature

Date

Time