

WILLIAM WOODS UNIVERSITY EMPLOYEE'S REPORT OF INJURY

TO BE COMPLETED FOR ALL WORK-RELATED INJURIES AND ILLNESSES

* All Boxes Must be Filled in Order to Comply with State Regulations *

TO BE COMPLETED BY INJURED EMPLOYEE: (Please Print)

Full Name		Today's Date	
Home Address		Social Security #	
City, State, Zip		Date of Birth	
Home Phone Number	Work Phone Number	Sex	Marital Status
What is your current position?		Date of Injury	
What department do you work for?		Time of Injury	
Who is your supervisor?	Supervisor's Title	Supervisor's Phone Number	
What job were you performing at the time of the injury?			
Where did the injury take place?			
In your own words, please explain what happened? (PLEASE BE SPECIFIC)			
What specific parts of your body were injured and what is the nature of the injury?			
Have you ever been under a doctor's care for the same or similar injury?			
What machine, tool or object was most closely connected with the injury, if applicable?			
Was this injury caused by someone or something outside the University? (Please explain)			
List the names of anyone witnessing your injury			
Do you have any other employment? (If so, where?)			
To whom did you report the injury?			
When did you report it? (If not immediately, please explain)			
Employee Signature		Date	

TO BE COMPLETED BY SUPERVISOR:

Name of medical facility where employee sent		Employee Date of Hire	Is the employee full-time or part-time?
Has the employee returned to work?	Date returned to work	What are the average number of hours the employee works per week?	What is the employee's hourly or weekly wage?
Supervisor Comments, if any			
Supervisor Signature		Date	

Fax immediately to Corporate Claims Management, Inc. at (314) 977-1457.