Check applicable category then complete form below:

☐ EMPLOYEE (injury/illness related to employment as checked below)

☐ UUP, CSEA, Council 82-represented or Management/Confidential complete this form, and call 1-888-800-0029 to report an injury and/or illness

☐ STATE STUDENT EMPLOYEE (Graduate Assistant, Work-Study, Student Assistant) complete this form, and call 1-888-800-0029 to report an injury and/or illness

☐ RESEARCH FOUNDATION EMPLOYEE

☐ RESEARCH FOUNDATION STUDENT EMPLOYEE (Research Project Assistant, Research Aide, Senior Research Aide)

☐ OTHER Official Volunteer or other (specify) ___________________

Employees/Others- Complete this form for any work related injury/illness and forward to Human Resources, 216 Bray Hall. State Employees call 1-888-800-0029 to report an injury and/or illness

☐ STUDENT (injury/illness not related to employment)

Students-complete this form and forward to Environmental Health & Safety, 19 Bray Hall.

Name _____________________________________________

Home address (Street, P.O. Box, City, State, Zip) __________________________________________________
__________________________________________________________________________________________

Home telephone (            ) _______________________

If injury:

Date and time injury occurred _____/_____/_____      _____am  _____ pm

Place of injury ________________________________________________________________________

If illness:

Date of exposure or symptoms _____/_____/_____  

Statement of how accident or exposure occurred; describe fully what happened, how it happened, body part(s) affected, and equipment or material in use at the time; use back of form if necessary 
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Name(s) and location(s) of any witnesses; attach statement(s) if available
___________________________________________________________________________________________

Was medical attention required?  YES   NO   If Yes, name and address of medical provider
____________________________________________________________________________________________

Signature _________________________________________________   Date _____________________________

If injury/illness is related to employment:

Unit where employed _____________________________  Location ____________________________________
Normal work schedule ____________________________

Were you on duty at the time the accident/exposure occurred? YES NO

Supervisor’s Signature ____________________________________ Date ____________________________
(Supervisor may make statement on reverse side)

(Continued from front side if necessary):

Supervisor statement:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Employee or Student statement of how injury/illness occurred:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

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