ALMA COLLEGE

FIRST REPORT OF INJURY/ILLNESS – EMPLOYEE REPORT

Submit via campus mail or electronically to duvalal@alma.edu

(To be completed by the employee within 24 of incident)

EMPLOYEE INFORMATION

Name _____

Home Address _____ Phone Number _____

City _____ State _____ Zip _____

Date of Birth _____ Sex M/F Marital Status S/M/Sep/W/D

Date of Hire _____ Job Title _____

Department _____ Work schedule: _____

EMPLOYEE'S REPORT OF INJURY/ILLNESS (Attached additional sheets as needed)

Date of Injury/Illness _____ Time _____

Date Reported _____ Reported to _____

Location of the Incident _____

Body part injured _____ Type of injury/illness _____

Describe in detail what happened:

_____

_____

_____

Witness (es) _____

Did you receive medical treatment Y/N If yes, where? _____

Have you been placed out of work over three days? Y/N

Is this a recurrence or aggravation of a previously reported injury/illness? Y/N If yes, please explain

_____

_____ _____

Employee Signature Date

Human Resources October 2018

ALMA COLLEGE

ALMA COLLEGE

FIRST REPORT OF INJURY/ILLNESS – SUPERVISOR REPORT

Submit via campus mail or electronically to duvalal@alma.edu

(To be completed by the supervisor within 24 of incident)

Employee's Name _____

Employee's Department _____ Title _____

Supervisor's Name _____ Supervisor's Phone _____

Date of the incident _____ Time _____

Date employee reported the incident _____ Incident Location _____

Witness (es) _____

What activity was the employee doing just before the incident occurred?

_____

_____

What happened? (Explain in detail how the incident occurred, attach additional sheets if necessary)

_____

_____

_____

_____

What object or substance directly harmed the employee?

_____

_____

Body part (s) affected (Check all that apply)

_____Abdomen	_____Elbow R/L	_____Hand R/L	_____Neck
_____Eye R/L	_____Head	_____Shoulder R/L	_____Arm R/L
_____Face	_____Hip R/L	_____Knee R/L	_____Wrist R/L
_____Chest	_____Foot R/L	_____Leg R/L	_____Ear R/L
_____Groin	_____Lungs	_____ Other _____	

Type of Injury (Check all that apply)

_____Absorption	_____Fracture	_____Laceration	_____Irritation
_____Inflammation	_____Over-exertion	_____Bruise	_____Ingestion
_____Over-exposure	_____Burn	_____Inhalation	_____Puncture
_____Foreign Body	_____Strain/Sprain	_____Other _____	

Type of Event (Check all that apply)

_____Body Motion/Body Position
_____Temperature extreme
_____Caught in/under/between
_____Vehicle Accident
_____Slip/twist
_____Explosion
_____Fall from elevation
_____Fall on same level
_____Unknown
_____Repetitive motion
_____Electrical contact
_____Struck by/struck against
_____Slip/trip/fall
_____Other _____

Where was the employee referred for medical care?

_____

What could the employee have done to avoid the injury?

_____

_____

List any other actions that will be taken or control measures that will be put in place to prevent recurrence.

_____

_____

Are you concerned with the validity of this claim? Y/N If yes, explain

_____

_____

_____ _____

Supervisor's Signature Date

For Human Resources Use Only

Date Received _____Submitted to Traveler's _____

Claim Number _____

Modified work requested Y/N If Yes, employee assigned to _____

Modified work duties _____

Follow up _____

Return to work date_____

Action form to Payroll_____