

**EMPLOYEE WORK-RELATED INJURY REPORT**

(This form should be completed in full and sent to the Workers' Compensation Office within 24 hours after the accident)

Employee Name: \_\_\_\_\_ Campus ID#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ ☐ Male ☐ Female

Employee Phone #: \_\_\_\_\_ Employee Home Address: \_\_\_\_\_

Employee Group: \_\_\_\_\_ Department: \_\_\_\_\_ Job Title: \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_

Incident Date: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ Time Shift Started: \_\_\_\_\_ Date Reported: \_\_\_\_\_

Describe what the employee was doing just before the incident occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the events that caused the injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Body Part(s) Injured (i.e., left arm, third finger right hand, etc.): \_\_\_\_\_

Where did the incident occur?: \_\_\_\_\_ Who witnessed this incident?: \_\_\_\_\_

(if no one, enter 'N/A' here)

To the best of my knowledge, the information identified above is correct:

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

**FOR HR USE ONLY:** (Non-emergency Care = ReadyCare/Comp, Emergency care = McLaren ER)

*\*Supervisors must contact HR immediately if an employee needs medical treatment following a work-related injury.*

Place of Initial Treatment: ☐ None ☐ Ready Care/COMP ☐ McLaren ER ☐ Other: \_\_\_\_\_

Treatment rendered: \_\_\_\_\_

Ongoing medical treatment for this injury? ☐ Yes  
☐ No

Employee Work Status: ☐ Continued to work normal scheduled hours without restrictions  
☐ Continued to work normal scheduled hours with restrictions  
☐ Did not return to work

If the employee was given work restrictions, please describe: \_\_\_\_\_

\_\_\_\_\_