Workers' Compensation Office
109 Rowe Hall
Phone: (989) 774-7177
Fax: (989) 774-3256
Email: workerscomp@cmich.edu

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: Select 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: _____
_____