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4.509:01 Employee's First Report of Injury

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Employee’s First Report of Injury

(To be completed and signed by the employee)

Employee Name (print): ____________________________________________ Campus: ______________________

Address_________________________________________ City________________________ State_____ Zip_________

Phone Number_________________________________________________ SS# ________________________________

Job Title___________________________________ Department______________________ Date of Hire_____________

Date of Injury__________________________  Time A.M/P.M.____________Date Injury Reported_________________

To Whom did you report the injury?____________________________________________________________________

Where were you when the injury occurred?_______________________________________________________________

Witness(es): _______________________________________________________________________________________

What activity were you performing when the injury occurred? (example: lifting, pushing, etc)
__________________________________________________________________________________________________

__________________________________________________________________________________________________

Describe how the injury happened:
__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Type of injury and what body part was injured?

(On the back of this form draw a circle around the exact part of the body that was injured)

Give name and address of treating physician /
hospital:___________________________________________________________________________________________
_________________________________________________________________________________

Have you had prior claims or treatment related to the same body part(s)?  Yes__________   No ______________

This is my description of the accident.  I hereby permit the release of medical information, records and reports relative to the issues necessary for the administration of my Worker’s Compensation claim to the necessary state agencies, my employer Antioch University and its authorized representatives, as such medical information, records and reports may possibly contain either allowed or alleged in my claim, or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Worker’s Compensation claim.  A copy shall be as good as the original.

__________________________________      _______________________________
Employee’s Signature       Date Form Completed