2-14-2012

4.509:01 Employee's First Report of Injury

Form # 4.509:01

ANTIOCH UNIVERSITY

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 boy 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**

EMPLOYEE SHOULD DRAW CIRCLE AROUND INJURED PART OF BODY