4.509:01 Employee's First Report of Injury

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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
EMPLOYEE SHOULD DRAW CIRCLE AROUND INJURED PART OF BODY