



# Injury/Illness Report

**Use this form to report ALL workplace incidents - on or off campus - involving Employees, Student Workers, and Students involved in Practicum Work Assignments.**

**Injured Employee/Student must complete Sections I & II – Please Print Clearly**

## EMPLOYEE/STUDENT INFORMATION

### Section I

Injured Employee/Student Name			Bear #		
Home Address		City	State	Zip Code	
Date of Birth	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status	Home Phone	Work Phone	
Department	Job Title	Campus Box	Hire/Work Start Date		
Supervisor/Faculty Name	Supervisor/Faculty Phone #	Supervisor/Faculty Email			

## ACCIDENT/ILLNESS INFORMATION

### Section II

Injury or Illness Date	List Time of Injury or Illness: AM <input type="checkbox"/> PM <input type="checkbox"/>	Was the accident or illness on UNC's property? If not where. YES <input type="checkbox"/> NO <input type="checkbox"/>
Location of Injury or Illness (Room # & Building or Company)	Date reported to Supervisor/Faculty	Time reported to Supervisor/Faculty AM <input type="checkbox"/> PM <input type="checkbox"/>
Time began work on date of injury AM <input type="checkbox"/> PM <input type="checkbox"/>	Did employee/student return to work after being injured? If YES, Date returned to work / /	YES <input type="checkbox"/> NO <input type="checkbox"/>
Name the object or substance which directly injured the employee/student (Be specific e.g. knee hit floor, fell-hand hit pavement, hammer struck finger etc):		
What were you doing when injured? – Describe how the injury or illness occurred and the part(s) of the body affected - Be specific and detailed (e.g. bending to pick up item felt a sharp pain in lower left back, slipped on ice while walking, gradual pain developed in shoulder over a course of 3 months, etc.) Identify <u>all body parts</u> that were injured.		
List all known witnesses (include Name and Phone Number)		
Employee/Student Signature	Date	

## EH&S and HR Use Only

### Section III

Date Received Report	Lost Time or Restrictions YES <input type="checkbox"/> NO <input type="checkbox"/>	WC Claim Number	Date Faxed to EH&S	HR Representative
Medical Provider (Hospital or Doctor) and Address			Phone Number	
City	State	Zip Code	Date of 1 <sup>st</sup> appointment	