



INJURY & ILLNESS REPORT

Full name: _____

Claim #: _____

Date of birth: _____

Contact phone number: _____

Address: _____

Gender: Male Female

Date of hire: _____

A#: _____

Job title _____

Department / work unit _____

Supervisor: _____

Shift start time: _____

Date of injury/illness _____

Time of the event: _____ AM PM

Event location: _____

Sought treatment from an emergency room: Yes No

Admitted as an in-patient to the hospital: Yes No

Name and address of medical facility: _____

Days away from work: _____ Dates of restricted/light duty: _____ to _____

Describe what you were doing before the incident occurred:

Describe how the injury / illness occurred:

What was the resulting injury/illness?

(i.e cut to finger, sprained muscle, chemical burn, etc.) _____

What object or substance directly caused the injury/illness? _____

Form completed by (print & signature): _____

Return a copy of this form to Evergreen's Office of Environmental Safety & Health (Taylor.Slaughter@evergreen.edu, Lab II 1246) and HRMedical@evergreen.edu

This form contains information related to an injured persons health and must be used in a manner that protects the confidentiality of the information while being used for occupational safety & health purposes to the extent possible.