

EMPLOYEE'S WORK INJURY AND ILLNESS REPORT

Florida Atlantic University
Environmental Health & Safety
777 Glades Road, Campus Operations Bldg.
Boca Raton, FL 33431
ehs-emp-rpt (07/08)

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. Records will be retained for five (5) years following the year to which they pertain.

PLEASE TYPE OR PRINT

INSTRUCTIONS:

1. **Notify your supervisor of your injury or illness immediately.**
2. **Complete this report within 24 hours of the injury or illness.**
3. **Notify Corvel (1-866-786-3351) of injury as soon as possible.**
4. **Submit the report to EH&S. (mail or fax to 297-2210)**
5. **Direct any questions to EH&S at 297-3129.**

FOR EH&S USE ONLY	
OSHA Recordable:	<input type="checkbox"/> Yes <input type="checkbox"/> No
OSHA 300 Log Number:	
If a death, Date of Death:	

Employee Name (as it appears on payroll)		Date of Birth:		Employee ID Number	
Street Address		City		State/Zip	
Job Title:		Department		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Hire:
Work Telephone ()	Home Telephone ()	Time Employee Began Work: Time of Injury:		AM PM AM PM	Date of Injury:
What were you doing just before the injury/illness occurred?					
Describe in <u>detail</u> what happened to cause the injury/illness, including what object or substance directly caused harm.					
Exact location where injury/illness took place? (inside, outside, building name, room, vehicle, etc.)					
Witnesses: (names, addresses, work telephone numbers)					
Date the injury/illness was reported to supervisor:					
Injury/Illness Information:					
Part of body injured (Check ALL that apply, and circle appropriate position) (Thumb = Finger 1, Great toe = Toe 1)					
<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	Back U M L	<input type="checkbox"/>	Finger R L 1 2 3 4 5
<input type="checkbox"/>	Ankle R L	<input type="checkbox"/>	Eye R L	<input type="checkbox"/>	Foot R L
<input type="checkbox"/>	Arm R L	<input type="checkbox"/>	Elbow R L	<input type="checkbox"/>	Hand R L
<input type="checkbox"/>	Other (Please specify)		For Hand and Arm injuries circle your dominant arm: Right Left		
If an illness, please specify.					
Was Medical Treatment Required?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name and Address of Medical Treatment Provider/Hospital	
Was employee treated in an Emergency Room?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Was employee admitted to hospital overnight?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
First aid only?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Time Lost From Work ?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If "Yes" how many days? _____					
Have you ever been treated for a similar injury or condition?		If Yes Date(s) of Treatment		Name of Practitioner, Hospital or Clinic Which Provided Prior Treatment for Similar Injury:	
<input type="checkbox"/> Yes <input type="checkbox"/> No					

Please read carefully. Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.

Employee Signature _____ **Date** _____

FOR EH&S USE ONLY		Primary Payroll Budget #		____%	
<input type="checkbox"/> AMP <input type="checkbox"/> SP <input type="checkbox"/> Volunteer		<input type="checkbox"/> Faculty <input type="checkbox"/> OPS <input type="checkbox"/> Other		Secondary Payroll Budget #	
Information Reviewed by:		Title:		Date	