INDIANA UNIVERSITY
COLUMBUS

Indiana University Columbus

EMPLOYEE INCIDENT REPORT / ILLNESS REPORT

File: ______________________ **Employee ID number:** ______________________

Name of subject: ______________________

Home address: ______________________

Home phone: (______)______________________ **work:** (______)______________________

Date of birth: ______________ **height:** __________ **weight:** __________ **Sex: female** ☐ **male** ☐

Date of incident: _______ month _______ day _______ year _____ time ☐ a.m. ☐ p.m.

Reported to supervisor: _______ month _______ day _______ year _____ time ☐ a.m. ☐ p.m.

Returned to work: ☐ yes ☐ no Regular work schedule: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thur. ☐ Fri.

Total days lost: _______ days _______ wage rate _______ H / BW / M **Total days lost:** _______ days _______ wage rate _______ H / BW / M

Payroll clerk: ______________________ **Account #:** ______________________
last name first name middle initial

Division/office:______________________ **Director:** ______________________

Hours worked on day of injury:__________ **I.U. employment date:**__________ **Employment date current position:**__________

Job classification:______________________

Exact place of incident:

____

____

Nature and extent of injury:

____

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____

Medical treatment by doctor: ______________________
☐ yes ☐ no name of doctor date

Medical treatment at hospital / clinic: ______________________
☐ yes ☐ no name of facility date

Police or ambulance arrive on the scene: ☐ yes ☐ no

Was a safety devise provided? ☐ yes ☐ no Was it used? ☐ yes ☐ no

Was a tool or other object involved? ☐ yes ☐ no Name of the or object: ____________________

Type of power:____________________ If object was lifted or carried (approximate weight): __________

If you have recommendations regarding the avoidance of future accidents, safety devices that should be used, or wish to propose safety regulations, do so at the end of this form by attaching to this form.

Employee signature: ____

date of this report

I HEREBY CERTIFY THE ABOVE IS A TRUE AND ACCURATE DESCRIPTION OF MY ACCIDENT.

Director signature: ____

Validation requires both employee and director signatures on this form.

Description of accident: Provide a complete description. If the accident was witnessed provide names, telephone numbers, what was seen, and what caused the accident. ____________________

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Witness(s):

Name: ____

Primary phone: ____

IMPORTANT INFORMATION

- Employee must sign the authorization release.
- If the accident involves exposure to human tissue, blood, or fluid, the employee is requires to take (in person) one copy of this form to the nearest hospital emergency room within 24 hours of exposure. If a sample of the source contamination can be obtained, take the sample with you for testing.

After completing the report, submit to: Division of Administration and Finance, CC Room 251

Authorization for medical information

This authorizes you to disclose to Indiana University-Purdue University Columbus (IUPUC), Division of Administration and Finance, all information regarding your condition while under observation or treatment at any time, including medical history and findings, consultation, prescriptions, treatment, x-ray, special consultation reports, diagnosis and prognosis, and copies of all hospital and medical records.

A copy of this authorization is considered as effective and valid as the original.

Witness signature:____________________

Address:____________________

____

Signature:____________________

Address:____________________

City: ____________________

State & zip: ____________________

Date: ____________________