IUPUC

Indiana University-Purdue 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: _____ last name first name middle initial **Account #:** _____

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:

_____

_____

_____

_____

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. _____

_____

_____

_____

_____

_____

_____

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 157.

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: _____