

WASHINGTON UNIVERSITY  
REPORT OF INJURY OR ILLNESS

Please check one:

- EMPLOYEE ON DUTY
EMPLOYEE OFF DUTY
STUDENT
VISITOR

CAMPUS BOX 1084
PHONE 935-5627
FAX 935-9795

For Office use only:

Case #
FA WC
LW NR
NS

PLEASE COMPLETE REPORT AS SOON AS POSSIBLE AND SEND TO CAMPUS BOX 1084 WHENEVER AN EMPLOYEE, STUDENT, OR VISITOR IS INJURED, OR BECOMES ILL WHILE ON UNIVERSITY PROPERTY.

- 1. NAME (First, Middle Initial, Last) 2. SOC. SEC.#
3. HOME ADDRESS (Street#, City or Town, State, Zip Code, Phone#)
4. DATE OF INJURY OR ILLNESS 5. TIME (A.M., P.M.)
6. MALE FEMALE 7. DATE OF BIRTH 8. MARRIED SINGLE
9. DEPARTMENT PHONE# CAMPUS BOX
10. GIVE EXACT LOCATION OF ACCIDENT OR ILLNESS (Bldg./Floor/Room)

11. DESCRIBE, IN DETAIL, HOW THE INJURY OR ILLNESS OCCURRED. (Use Additional Sheets, if Necessary)

- 12. NAME(S) OF WITNESSES
13. DESCRIBE INJURY/ILLNESS AND INDICATE SPECIFIC BODY PART(S) AFFECTED.

14. Signature of Employee or Person Completing Report and Date Signed. (First, Middle Initial, Last, Date Signed)

SUPERVISOR OR DEPARTMENT

- 15. WHERE WAS THE PERSON SENT FOR MEDICAL TREATMENT?
16. PERSON'S REGULAR OCCUPATION 17. DATE EMPLOYED
18. HOW LONG AT CURRENT OCCUPATION? Yrs. Mos. 19. FULL TIME PART TIME
20. DAYS WORKED DURING WEEK 21. HOURS WORKED PER WEEK
22. TIME STARTED WORK 23. EMPLOYEE'S RATE OF PAY \$
24. DID PERSON LOSE TIME? YES NO 25. IF YES, DATE OF RETURN TO WORK IF KNOWN
26. IS FURTHER MEDICAL TREATMENT REQUIRED? YES NO UNKNOWN
27. BASED ON YOUR INVESTIGATION, WHAT ARE THE CAUSE(S) OF THIS ACCIDENT/ILLNESS?
28. WHAT CORRECTIVE ACTION(S) ARE IN PROGRESS, ALREADY TAKEN, OR PLANNED TO PREVENT RECURRENCE OF THIS INJURY OR ILLNESS?
29. NAME OF SUPERVISOR/DEPARTMENT REPRESENTATIVE COMPLETING REPORT.

Print and Sign Name: Phone# Box # Date Signed

SEND OR FAX TO THE INSURANCE/SAFETY OFFICE, BOX 1084