UNIVERSITY OF ILLINOIS at URBANA-CHAMPAIGN
EMPLOYEE'S INJURY REPORT

Every work-related injury or disease is to be reported to your direct supervisor.
Please TYPE or PRINT CLEARLY in the spaces provided.

EMPLOYEE SECTION

IS THIS A CLAIM FOR WORKERS' COMPENSATION? ☐*Yes* ☐*No*

PERSONAL INFORMATION

Name_____ SSN_____-_____-_____
Street_____ Phone_____ UIN_____
City_____ State_____ Zip_____ Birth Date_____
Sex *M* *F* Marital Status *S* *M* *Sep* *W* *D* Number of Children Under Age *18*_____

EMPLOYMENT INFORMATION

Job Classification ☐*Academic Professional* ☐ *Faculty* ☐ *Staff* ☐ *Student* ☐ *Extra Help*
Job Title_____ Department_____
Work Days Scheduled Per Week *M T W R F S S* Hours Scheduled Per Work Day_____
Campus Phone_____ Date of Hire_____

EMPLOYEE'S REPORT OF ACCIDENT/INJURY

Date of Accident/Injury_____ Time____:____ ☐*AM* ☐*PM* Date Reported_____
Exact Location of Accident: Room #_____ Building and/or Address_____

Description of Accident "While_____
_____
_____
_____
_____

Body Part Injured_____
_____

Recommendation for Prevention_____

Did you report this to your supervisor? *Yes* *No*
If no, to whom?_____

Do you have a second job? *Yes* *No*
If yes, where?_____

Did you receive medical treatment? *Yes* *No*
If yes, at what facility did you receive treatment?_____

Is this a recurrence/aggravation of a previously reported injury? *Yes* *No*
If yes, please explain_____

WITNESSES OF ACCIDENT/INJURY

Name_____ Campus Phone_____ Home Phone_____
Home Address_____

Name_____ Campus Phone_____ Home Phone_____
Home Address_____

I attest that the above information is true and correct.

_____ _____
Signature of Employee Date

EMPLOYEE'S NAME_____

SUPERVISOR SECTION

Complete this side of the injury report and forward immediately according to the instructions at the bottom of this page.
Please TYPE or PRINT CLEARLY in the spaces provided.

SUPERVISOR'S REPORT

Your Name_____ Home Phone_____
Title_____ Campus Phone_____

Were you an eyewitness to this accident/injury? *Yes* *No*

If so, describe the accident/injury._____

If not, how and when did you learn of the accident/injury?_____

What was reported to you?_____

Did the employee seek medical care? *Yes* *No*
Where did the employee go for medical attention_____

What could the employee have done to avoid the injury?_____

Is the employee on University Payroll? *Yes* *No*

Is the employee currently working? *Yes* *No*

Employee's Department_____ Employee's Department Code_____

Wage Account From Which Employee Was Paid on Date of Accident_____

_____ _____
Signature of Supervisor Date

If there are any questions, please call Claims Management Office at (217) 333-1080

SEND ORIGINAL TO: Office of Claims Management, 100 Trade Centre Drive, Suite 103, Champaign, IL 61820 MC-686

ONE COPY EACH TO: Office of Campus Risk Management, 1110 W. Springfield, Urbana, IL, 61801 MC-240
Division of Safety & Compliance, 1501 S. Oak Street, Champaign, IL 61820 MC-821

RETAIN A COPY FOR YOUR DEPARTMENTAL RECORDS

(REV 03/2006)