



<i>Employee Information</i>		
Name of Injured Employee:		<input type="checkbox"/> Male <input type="checkbox"/> Female
Job Title:	Department:	
Employee Home Address (street, city, state, zip):		Home Phone #:
SSN:	Date of Birth:	WFU Hire Date:
Wage/Salary Info (HR to complete):		Hrs/Days Worked per Week: /
<i>Incident Information</i>		
<input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Vehicle Accident (If vehicle accident, also complete Form?)		
Date of Incident:	Date Incident Reported:	
Did the incident result in lost workdays? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list dates:		
Was employee interviewed by supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervisor's Name:	
Date of Interview:	Were Witnesses Present? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name(s) of Witness(es):		
Were other employees involved in the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name(s) of Other Employee(s):		
Was first aid administered at WFU? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	By Whom?
Was EMS dispatched? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was employee sent to hospital/clinic for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital/Clinic where employee was sent:		Authorized By:
Did employee receive Rx for injury/illness?		Treating Physician:
<i>Description of Incident</i>		
What time did employee begin work?	What time did incident occur?	
Where did injury/illness/vehicle accident occur? (Include building, room#, area of campus)		
What was employee doing before injury/illness/vehicle accident occurred? (Please be specific)		
How did the injury/illness/vehicle accident occur? (Please be specific)		

