

EMCBC Supervisor's Injury/Illness Report

Attention: this form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes

Instructions: This form must be completed and returned to Office of Human Resources and Office of Technical Support and Asset Management within 24 hours of the injury/illness. Every question of this form must be answered, if question does not apply insert N/A.

(1) Employee Information			<i>Please Print Clearly</i>
Last Name, First Name, M.I.	Status: Employee____ Working Student ____		
Supervisor's Name:	Supervisor's Phone:	Date supervisor was first made aware of injury/illness:	
(2) Description of Incident			
Date of injury/illness:	Time employee began Work:		
Time of Incident: _____ AM or PM	Was EMS notified? Yes___ No___		
<i>Where did injury/illness occur? (List specific location)</i>			
<i>What had the employee been doing just before the injury/illness resulted? (Be specific about equipment and activities, i.e. walking down steps, moving chairs, drinking coffee)</i>			
<i>What happened? (How did the injury/illness occur? i.e. ladder slipped and employee fell 6 feet, spilled hot coffee on arm)</i>			
<i>What object or substance directly harmed the employee? (i.e. floor, hot coffee)</i>			
Did individual receive supervised training for the type of work being performed? Yes___ No___	If yes, by whom and when?		

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May be exempt from public release under the Freedom of Information Act (5 U.S.C. 552). Exemption number and category: 6- Personal Privacy. Department of Energy review required before public release.

Name * _____ Date: _____ Guidance (if applicable): _____

*The person completing this form should sign and date. This document becomes Official Use Only when completed.

How can this type of injury be avoided in the future?		
If there was a witness(es) to the incident, please list name(s) and telephone number(s)		
(3) Description of Treatment		
Was injured employee treated? Yes ___ No ___	Date treatment was received:	
Name of treating physician or other Health Care Professional:	Was employee treated in an emergency room? Yes ___ No ___	Was employee hospitalized overnight as an in-patient? Yes ___ No ___
Where was treatment given (at worksite or health care facility name and address) leave blank if unknown.		
Nature of injury (sprain, bruise, inhalation of chemicals, etc)	Specific part of body injured (i.e. left index finger, right knee)	
Is/was employee away from work as a result? Yes ___ No ___	Last date worked: _____ Last day paid in full: _____ Date returned to work: _____ Number of days missed: _____	
(4) Signatures		
_____	_____	_____
Injured Persons Signature		Date
_____	_____	_____
Supervisor's Signature		Date

Questions about reporting a work-related injury or illness? Contact the Office of Human Resources.

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