

LA SIERRA UNIVERSITY

INJURY and ILLNESS INCIDENT REPORT

PART 1 - TO BE COMPLETED BY INJURED / ILL EMPLOYEE (Please Print):					Case #
Full Name	Social Security	Date of Birth (MO/DAY/YEAR) ____/____/____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Home Address		City	State	Zip	
Home Phone	Cell Phone	Supervisor Name		Supervisor Extension	
Department	Job Title		<input type="checkbox"/> Student <input type="checkbox"/> Volunteer		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Date Hired (MO/DAY/YEAR)			Daily Start Time (AM/PM)		
Date of Injury or Illness ____/____/____ (MO/DAY/YEAR)			Time Injury Occurred (AM/PM) Hour _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Check if time cannot be determined		
Describe injury or illness, including what, where, why and how the injury or illness occurred: _____ _____					
Employee Signature	Date	Report Completed by:	Date	Phone Number	
PART II – TO BE COMPLETED BY HUMAN RESOURCE OFFICIAL (WITHIN 24 HOURS OF KNOWLEDGE OF INCIDENT)					
Date of Injury/ Illness	Time of Injury/Illness Hour _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		Medical Treatment provided by: <input type="checkbox"/> Workers Comp Clinic <input type="checkbox"/> Student Health Service <input type="checkbox"/> EMT <input type="checkbox"/> Medical Treatment Declined <input type="checkbox"/> No Medical Treatment Provided		
Date of knowledge of injury			Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was Employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name of Physician or other health care professional		
Name of Physician or other health care professional			Address of Physician or other health care professional:		
Describe injury or illness, including what, where, why and how the injury or illness occurred (Based on supervisor's report and eyewitnesses): _____ _____					
What action(s) have been or will be taken to prevent reoccurrence? _____					
Part of Body (check all that apply) Indicate Right or Left when Applicable		Type of Injury (Check)		Name of Witness / Dept / Phone #	
1. <input type="checkbox"/> Head 10. <input type="checkbox"/> Wrist 19. <input type="checkbox"/> Neck 2. <input type="checkbox"/> Face 11. <input type="checkbox"/> Hand 20. <input type="checkbox"/> Shoulder 3. <input type="checkbox"/> Eye 12. <input type="checkbox"/> Finger 21. <input type="checkbox"/> Groin 4. <input type="checkbox"/> Ear 13. <input type="checkbox"/> Knee 22. <input type="checkbox"/> No Injury 5. <input type="checkbox"/> Mouth 14. <input type="checkbox"/> Leg 23. <input type="checkbox"/> Other 6. <input type="checkbox"/> Heart 15. <input type="checkbox"/> Ankle 7. <input type="checkbox"/> Back 16. <input type="checkbox"/> Foot 8. <input type="checkbox"/> Trunk 17. <input type="checkbox"/> Toe 9. <input type="checkbox"/> Arm 18. <input type="checkbox"/> Hip		1. <input type="checkbox"/> Reaction to foreign substance/objects 2. <input type="checkbox"/> Puncture 3. <input type="checkbox"/> Laceration 4. <input type="checkbox"/> Contusion 5. <input type="checkbox"/> Burn 6. <input type="checkbox"/> Fracture 7. <input type="checkbox"/> Amputation 8. <input type="checkbox"/> Sprain/Strain 9. <input type="checkbox"/> Other _____		1. _____ 2. _____ 3. _____	
Did injury cause absence from work? <input type="checkbox"/> Yes <input type="checkbox"/> No			Has Employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		
Department Head Signature	Title	Date	Office Extension #		