Please check one:
- ☐ EMPLOYEE ON DUTY
- ☐ EMPLOYEE OFF DUTY
- ☐ STUDENT
- ☐ VISITOR

WASHINGTON UNIVERSITY
REPORT OF INJURY OR ILLNESS

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 ______________________________ 2. SOC. SEC.# ______________
   First Middle Initial Last
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/ILLLNESS? ______________
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