MIDDLESEX COMMUNITY COLLEGE

EMPLOYEE WORK-RELATED INJURY/ILLNESS REPORT

SECTION I: FOR COMPLETION BY THE EMPLOYEE

Name: _____
(First) (Middle) (Last)

Sex: ☐Male ☐Female Social Security Number_____

Employee Identification #:_____ Record #:_____

Employee Home Address: Street _____

City: _____ State:_____ Zip:_____

Home Telephone: _____ Date of Birth _____

Marital Status: ☐ Married ☐Single ☐Divorced

EMPLOYMENT INFORMATION

Position Title:_____

Department: _____

Campus:_____ Building:_____ Room #:_____

Status: ☐Full-Time Employee ☐Part-Time Employee Work Hours/Week_____

Shift: ☐1st ☐2nd ☐3rd Number of scheduled days off per week _____

INJURY/ILLNESS INFORMATION

Date of Injury/Illness: _____ Time of event: _____A.M./P.M.

Time work began on date of injury/illness: _____A.M./P.M.

Event occurred: ☐Before ☐During ☐After Work Shift

Date reported: _____ Injury/Illness reported to: _____

What were you doing just before the event occurred? *Describe the activity as well as any tools, equipment or material you were using. Be specific. Example: Walking down the hallway carrying supplies.*

_____

How did the injury or illness occur? *Example: I tripped over an electrical cord and fell to the floor.*

_____

_____

_____

What was the source of the injury or illness? *Source means the object or substance that directly harmed you. Example: The floor*

_____

Nature of injury or illness: *Describe the nature of the injury or illness. Examples: Sprain, contusion, disorder of the eye*

_____

Body part(s) affected: *Examples: right wrist, low back*

_____

Where did the injury or illness occur?

Campus:_____ Building:_____ Room #:_____

Specific Location: _____

Was the event witnessed? ☐ Yes ☐ No
If Yes, complete the following:

Name of Witness: _____

Title_____Telephone_____

Name of Witness: _____

Title_____Telephone_____

Name of Witness: _____

Title_____Telephone_____

Did you lose consciousness? ☐ Yes ☐ No

Did you seek medical attention? ☐ Yes ☐ No

If Yes, were you treated in an emergency room? ☐ Yes ☐ No

If Yes, were you hospitalized overnight as an inpatient? ☐ Yes ☐ No

If Yes, please provide the following information concerning treatment at any medical facilities, including but not limited to hospitals, doctors' offices and urgent care centers:

a. Name of Facility/provider:_____
b. Street:_____

c. Town: _____

d. Zip Code: _____ e. Phone Number:_____

If you received treatment at more than one location or from more than one provider, please attach information concerning the additional locations and/or providers on a separate sheet of paper.

Do you expect to lose time from work? ☐ Yes ☐ No

Employee Signature_____

Date_____

SECTION II: FOR COMPLETION BY THE SUPERVISOR

Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

Date Supervisor received report of employee's injury:_____

Supervisor Signature_____

Date_____

SECTION III: FOR COMPLETION BY THE DEPARTMENT MANAGER

Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

Date Supervisor received report of employee's injury:_____

Manager Signature_____

Date_____