|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EMPLOYEE Information | | | | | |
| First Name |  | | | | | | | | | | | | | | | | | | | | | | | | | Last Name | | | |  | | | | | | | | | | | | | | | | | |
| Street Address |  | | | | | | | | | | | | | | | | | | | City | |  | | | | | | | | | | | | | | | | | | | | ZIP | | | |  | |
| County |  | | | | | | | | | | | | | Phone # | | |  | | | | | | | | | | | | | | | Gender | | | Male  Female | | | | | | DOB | | | Click or tap to enter a date. | | | |
| Job Title |  | | | | | | | | | | | | | | | | | | | | | | | Department | | | | | |  | | | | | | | | | | | | | | | | | |
| Supervisor Name |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employment Status | | | | | | | | Full-time  Part-time | | |
| Injury/Illness INFORMATION | | | | | | | | | | | To ensure your medical treatment will be paid by Worker’s Compensation, you must obtain treatment by a provider listed on the [IUP Panel of Physicians](IUP%20Panel%20of%20Physicians%202017.pdf) within the first 90 days of the injury/illness. Please inform the health care provider that your injury/illness is work-related. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Injury/Illness | | Click or tap to enter a date. | | | | | Time of Injury/Illness | | | | | | | | : | | | AM  PM | | | | | Date Injury/Illness Reported | | | | | | | | Click or tap to enter a date. | | | Start of Shift on Date of Injury/Illness | | | | | | | | | : | | | | AM  PM |
| Employee’s regular work schedule | | | | | | | | : | | | | | AM  PM | | | to | | | : | | | | | | | | | AM  PM | Monday | | | | | | | | | | Monday | | | | | | | | |
| Address/Location of Injury/Illness: (be as specific as possible) | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Description of injury/illness & body parts affected: (be as specific as possible) | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe the cause and the events which resulted in the injury/illness: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Equipment, materials and/or chemicals in use when injury/illness occurred: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Was anyone else present when the injury/illness occurred? | | | | YES  NO | | | | | | If YES, please provide their name and contact number: | | | | | | | | Witness Name: | | | | | | |  | | | | | | | | | | | | | Witness Phone #: | |  | | | | | | | |
| Was employee working his/her regular shift at the time of injury/illness? | | | | YES  NO | | | | | If NO, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Initial Treatment: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treating Physician/Health Care Provider: | | |  | | | | | | | | | | | | | | | | | | | | | | | | Treating Hospital/Clinic: | | | | | |  | | | | | | | | | | | | | | |
| Has the injury/illness caused the employee to miss any work? | | | | YES  NO | | | | | If YES, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employee’s Expected or Actual Date of Return | | | | | | | | | | | | Click or tap to enter a date. | | | | | | | | |
| Additional Information/Comments: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employee Signature: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | |
| Supervisor Signature: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | |
| Please fax completed form to the Office of Human Resources (724-357-2685) or email electronic form to [ashively@iup.edu](mailto:ashively@iup.edu?subject=Employee%20Workplace%20Injury/Illness%20Incident%20Report%20submission) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |