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| --- |
| 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 |