Injury Report Form

TODAY'S DATE: ____________________

THIS SECTION TO BE COMPLETED BY INJURED PERSON

Employees and Student Employees:
This form is intended to be printed, then completed by filling in the blanks. Please print legibly.
Complete front and back of this page with your supervisor and turn it in to the Human Resources Office (Garfield Station).

Name ____________________________________________________________ PLU ID# __________________________

You are (circle one) Employee    Student Employee

Date of injury _______________ Time injury occurred _______________ Time shift began _______________

Location injury occurred ____________________________________________________________

Witness Name                  E-mail                  Telephone

<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
<th>Telephone</th>
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Body part affected (check all that apply, circle “R” for right, “L” for left)  □ Head     □ Neck     □ Torso

□ Shoulder (R  L)  □ Arm (R  L)  □ Elbow (R  L)  □ Leg, upper (R  L)  □ Leg, lower (R  L)

□ Knee (R  L)       □ Hip (R  L)  □ Back, lower  □ Back, upper  □ Ankle/foot (R  L)

□ Hand/fingers (describe) _______________________________  □ Other (describe) _______________________________

Activity(s) that led to injury  □ Lifting     □ Reaching     □ Bending     □ Twisting     □ Driving

□ Carrying         □ Climbing     □ Pushing/Pulling □ Cutting/chopping □ Keyboarding

□ Other (describe)  ___________________________________________________________________________________

Was this a cut or needlestick injury that involved another person’s blood or bodily fluid?  □ Yes  □ No

Tools, chemicals, or hazardous equipment involved ____________________________________________

Describe incident (include activities just prior to accident, attach page or photos, if necessary):

____________________________________________________________________________________________________________________________________

Treatment  □ First Aid     □ Urgent Care     □ Emergency Room     □ Admitted to Hospital

(check any that apply)

Doctor or other provider(s) seen ______________________________________________________________________________________________________

Medical attention received _____________________________________________________________________________________________________________

Your Signature: ___________________________________________  Date: ____________________________

rev. 3.18.2021
Please complete this as soon as possible after the accident. Any lost time or light duty days not noted here must be reported to Human Resources as soon as that information is available.

**THIS SECTION TO BE COMPLETED BY PLU EMPLOYEES WITH THEIR SUPERVISORS**

<table>
<thead>
<tr>
<th>Employee’s Department</th>
<th>Job Role/Title</th>
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<thead>
<tr>
<th>Hire Date</th>
<th>Employee type (circle one)</th>
<th>Full time</th>
<th>Part time</th>
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<tr>
<th>Work schedule (day: hours)</th>
<th>Mon:</th>
<th>Tues:</th>
<th>Wed:</th>
<th>Thurs:</th>
<th>Fri:</th>
<th>Sat:</th>
<th>Sun:</th>
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Could this accident have aggravated a pre-existing injury or illness?  
Yes  No

If yes, explain:

Were there any unsafe conditions that contributed to this accident?  
Yes  No

If yes, explain:

Do you have any suggestions for correcting these conditions?

Was a supervisor able to inspect the accident area promptly?  
Yes  No

**Additional Comments** (anything else to assist in analyzing why/how this occurred---facts only, no opinions please)

**THIS SECTION TO BE COMPLETED BY SUPERVISOR**

Please complete this as soon as possible after the accident. Any lost time or light duty days not noted here must be reported to Human Resources as soon as that information is available.

 Date(s) of work time lost ________________________  Date(s) of restricted work duties ________________________

 Date returned to work ________________________

Supervisor Comments

Supervisor Name (print) ________________________

Supervisor Signature ________________________  Date ________________________