PLU

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

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) _____

Tools, chemicals, or hazardous equipment involved _____

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

Treatment (*check any that apply*) ☐ First Aid ☐ Sent Home ☐ Urgent Care/Emergency Room

Doctor or other provider(s) seen _____ ☐ Admitted to hospital

Medical attention received _____

Your Signature: _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY PLU EMPLOYEES WITH THEIR SUPERVISORS

Employee's Department _____ **Job Role/Title** _____

Hire Date _____ **Employee type** *(circle one)* Full time Part time

Work schedule *(day: hours)* Mon: _____ Tues:_____ Wed:_____ Thurs:_____

Fri:_____ Sat:_____ Sun:_____

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)*

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** _____