Injury Report Form

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 ________________________________________________________________

<table>
<thead>
<tr>
<th>Witness Name</th>
<th>E-mail</th>
<th>Telephone</th>
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<tbody>
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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) ___________________________________________________________________________________

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**

<table>
<thead>
<tr>
<th>Employee’s Department</th>
<th>Job Role/Title</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Hire Date</th>
<th>Employee type (circle one)</th>
<th>Full time</th>
<th>Part time</th>
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<table>
<thead>
<tr>
<th>Work schedule (day: hours)</th>
<th>Mon:</th>
<th>Tues:</th>
<th>Wed:</th>
<th>Thurs:</th>
</tr>
</thead>
<tbody>
<tr>
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<td>_______________</td>
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<table>
<thead>
<tr>
<th>Fri:</th>
<th>Sat:</th>
<th>Sun:</th>
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<tbody>
<tr>
<td>_____________</td>
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</table>

**Could this accident have aggravated a pre-existing injury or illness?**

Yes  No

If yes, explain:

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**Were there any unsafe conditions that contributed to this accident?**

Yes  No

If yes, explain:

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**Do you have any suggestions for correcting these conditions?**

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**Was a supervisor able to inspect the accident area promptly?**

Yes  No

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

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**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.

<table>
<thead>
<tr>
<th>Date(s) of work time lost</th>
<th>Date(s) of restricted work duties</th>
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**Date returned to work**

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**Supervisor Comments**

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**Supervisor Name (print)**

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**Supervisor Signature**

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