KNOX COLLEGE
WORK INJURY REPORT

Full Name_____ID No._____

Home Address_____City/State/Zip_____

Home Phone_____ Work Phone_____

Date of Injury or illness _____/_____/_____ Time of injury_____AM/PM

Time employee began work _____AM/PM Witness(s)_____

Location of
Accident_____

What was employee *doing* just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing material"; "spraying chlorine from a hand sprayer."

_____

_____

What happened? Tell us how the injury occurred. *Examples*: "When ladder slipped on wet floor, worker fell 20 ft"; "Worker was sprayed with chlorine when gasket broke during replacement."

_____

_____

What was the injury or illness? Tell us the part of the body that was affected and how it was affected; <u>be specific</u>. *Examples:* "strained lower back"; "chemical burn, left hand."

_____

_____

What object or substance directly harmed the employee: Examples: "concrete floor"; "chlorine." *If this question does not apply to the incident, leave it blank.*

_____

_____

Employee's recommendation of how to prevent recurrence.

_____

_____

Signature of
Employee_____Date_____

To be completed by Supervisor:

Person Accident Reported to:_____ Date/Time Accident Reported:_____

What caused the accident?_____

How could accident have been prevented:_____

What corrective action, if any, has or will be taken _____

If treatment was given away from the worksite, where was it given?

Facility:_____

Name of physician or other health care professional:_____

If treatment was provided at St. Mary's Occupational Health, who called?_____

If hospitalized, name and address of hospital_____

_____ Ext._____
Signature of Supervisor

_____ Ext_____
Signature of Director

For Personnel Use Only:

Name of Employee _____Case # from log_____

Male / Female Married / Single

SS#_____Date of birth____/____/_____ Date hired____/____/_____

No. of Dependents_____

Occupation_____ Dept._____

FT / PT Wage $_____hr Work week_____ hrs

St. Mary Occupational Health Clinic 344-9411

Date phoned in_____ By: _____ Report #_____