

Occupational Injury or Illness Report

This form contains sections to be completed by both the supervisor and the employee.

The accident should be investigated by the supervisor of the injured employee or department involved.

It should be completed soon as possible to obtain the most accurate information.

Date of Injury:		Date Reported:		CALM Member Name: Northeastern State University	
Name of Employee:			S.S. No:		
Home Address:					
Home Phone:		Work Ext:		Date of Birth:	
Cell Phone:					
Sex:		Occupational Title:		Date of Employment:	
Time Work Shift Began: AM/PM			Time Accident Occurred: AM/PM		Day of week M T W TH F S SU
Location:					
Injury Type (Circle)		Comments, if any			
25	Foreign Body in Eye	81	Animal, Insect, Human Bite	28	Fracture
43	Cut/Puncture	46	Hernia/ Rupture	02	Amputation
40	Abrasion/Scratches	99	Heart Attack/Stroke	68	Skin Irritation/ Dermatitis
10	Bruise/Contusion/Crushing	72	Hearing Impairment	07	Concussion/ Loss of Consciousness
49	Sprain/Strain	66	Exposure (Chem. Temp. Elect)	24	Death
04	Burn (Chem, Liquid, Electrical)	81	Exposure (Blood/ Body Fluid)	00	Other
Injury Cause (Circle)		Comments, if any			
46	Struck by/ Against Object	31	Noise	85	Animal, Insect, Human
25	Fall-Same Level, Different Level	98	Repetitive Motion/Trauma	84	Hot Object, Substance or Fire
54	Jumping or Climbing	30	Slipping/Tripping	26	Caught in/Under/ Between
48	Vehicle Accident/ Struck by Vehicle	57	Pushing/Pulling/ Lifting/ Carrying	59	Other
Was injury caused by another person, faulty/broken equipment, a vehicle?			Yes	No	
If yes, explain:					
Body Part Injured (Circle)		Comments, if any			
02	Head/Neck/Face/Mouth	44	Wrist (Left Right)	74	Hips/ Buttocks
05	Eye (Left Right)	45	Hand (Left Right)	46	Fingers (Left Right) Digit:
04	Ear (Left Right)	61	Back (Upper Lower)	83	Knee (Left Right)
48	Shoulder (Left Right)	67	Chest/Abdomen Including internal organs	85	Ankle (Left Right)
41	Arm (Left Right)	66	Pelvis/ Groin	86	Foot (Left Right)
42	Elbow (Left Right)	82	Leg (Thigh Calf)	87	Toes (Left Right) Digit:
73	Respiratory	01	Other	96	No Physical Injury
First Aid or Medical Treatment					
Was first aid given?			Yes	No	If yes, by whom:
Was medical treatment required by a physician or hospital?				Yes	No
Physician/ Hospital Name, Address, and telephone number:					

Explanation of injury (How, When, Where)

Date you first noticed the pain?

Did this pain develop gradually? Or suddenly?

If the pain developed suddenly, exactly what were you doing when the pain was felt?

If nothing unusual or unexpected happened, what do you think caused the pain?

List body parts injured:

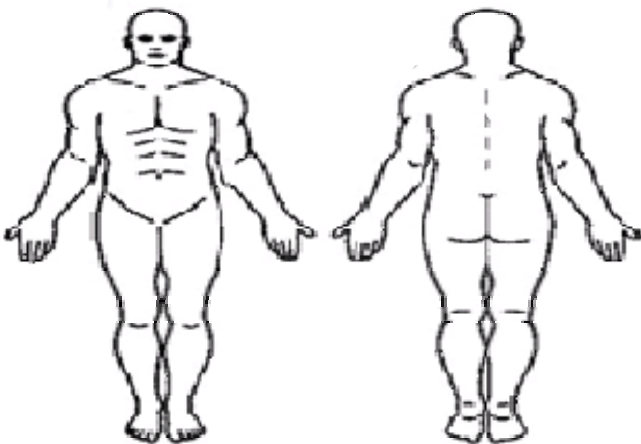
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No

Have you had any recent non-work related injuries/illnesses? If yes, please list: Yes No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?

Show part(s) of the body injured, noting the longevity, type and degree of pain.

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.
 Example: "A-6= Ache- Severe pain"

	Note type of pain:	
	A = Ache	B = Burning
	N = Numbness	S = Stabbing
	P = Pins & Needles	O = Other
	Note level of pain:	
	0	No Pain
	1	Mild pain, you are aware of it, but it doesn't bother you
	2	Moderate pain that requires medication to tolerate the pain
	3	More severe pain
	4	Severe pain
5	Intensely severe pain	
6	Most severe pain, unbearable	

Was medical treatment away from the job site offered? Yes No

If treatment was offered, but declined, please sign:

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.

Employee Name: (Print)

Employee Signature: Date:

Supervisor's Statement

As a result of your investigation, what do you believe occurred and why?

From your investigation is the validity of the accident in doubt? Yes No If yes, explain why.

Was a third party at fault? If yes, explain

Were there any witnesses? If yes, please list

Name	Address	Phone	Date

Supervisor's Signature: