REPORT OF ON-THE-JOB INJURY OR ILLNESS
WORKERS' COMPENSATION CLAIM FORM

UNIVERSITY of INDIANAPOLIS

Please type or print in ink to complete this form and send electronically to Matt Cunningham at mcunningham@uindy.edu or by campus mail to Human Resources, Esch Hall. Any questions about this form or the information requested should be directed to Human Resources.

INJURED WORKER INFORMATION

Name (last, first, middle)		Job Title	Date Hired
Date of Birth	☐ Male ☐ Female	Department	
Home Address Phone (_____) _____-_____	Supv. Name Phone (_____) _____-_____	Work Status ☐ Full-time ☐ Part-time ☐ Student Worker ☐ Graduate Student Worker	

This form completed by: (please provide e-mail address) ☐ Injured Worker ☐ Supervisor ☐ Other (Name, title, phone)

INCIDENT INFORMATION

Type: ☐ Injury ☐ Illness	Date of incident or knowledge of illness:	Time of Occurrence: _____ ☐ Time cannot be determined	Reported to Supv on:

What was the employee doing just prior to the incident? (Describe the activity and any tools, equipment and material being used.)

What happened? (Tell us how the incident occurred. Example: "when ladder slipped on wet floor, worker fell", or "worker sprayed with chlorine when gasket broke during replacement")

What was the injury or illness? (Tell the part of the body affected and how it was affected. Example: "bruised and cut right knee" or "sprained back")

What object or substance directly harmed the employee? (Example: "concrete floor" or "steps")

Was the incident reported to the campus police? (circle one) ◯YES /◯NO

Is there a potential outside liable party responsible for the cause of this incident? (i.e. outside contractor, etc.)

Witness(es) [Name(s), Phone or email(s)]:

TREATMENT INFORMATION (CHECK ONE)

☐ No medical treatment needed/self care
☐ Community Health Network
☐ Other*

Name of physician, health care provider, hospital or other offsite treatment facility

Opportunity to seek medical treatment refused.

_____
(Employee signature & date)

ACCIDENT SITE INSPECTION NOTES

(The Worker's Compensation Safety Committee requests that the accident site be investigated by supervisor immediately. Please provide description of condition, location and other details of the site.)

☐ I confirm that the information given in this form is true, complete and accurate.

Signature:	Date:

2/2018