

FIRST REPORT OF INJURY

EMPLOYEE INFORMATION

Employee Name:	Department Number:	Date of Hire:	Operations and Maintenance employee? YES NO
Compensation provided by:	Supervisor Name:	Supervisor Telephone:	Person Completing Form:

INCIDENT INFORMATION

Date of Injury or Illness: Date is Approximate	Time of Event: Cannot be Determined	Time Employee Began Work:
What was the employee doing just before the incident occurred?		
How did the injury occur?		
What part of the body was affected?	How was it affected?	
What object or substance directly harmed the employee?		
In what building did the incident occur? (If Applicable)		
What is the exact location of the incident?		
Do you expect the employee to lose work beyond the date of injury? YES NO	If YES, what was the last day worked?	If employee died, when did death occur?
Were there any witnesses? YES NO	If YES, list witnesses:	

TREATMENT INFORMATION

Did the employee require treatment from a medical provider?	YES	NO
If so, where was the treatment given?* (If the facility is not in the campus dropdown lists, select "Other" and enter the facility in the field that appears.)		
West Lafayette	IPFW	Northwest (Hammond)

* (E or AA) = Emergency or After Hours

RESOURCES

Supervisor's Accident/Near-Miss Investigation Form	Worker's Compensation Website
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SUPERVISOR ONLY

The preferred way to submit this form is via email by using a "Submit by Email" button on this page. The email submission method is the gold-standard. Faxing and phone calls should only be used when a computer is not available.

If a computer is not available, print and fax this form to JWF Specialty at (678) 666-1210 or call Christie Nygaard (317) 706-9591.