



EMPLOYEE'S REFERRAL SLIP FOR INDUSTRIAL INJURY AND REPORT OF ACCIDENT

Supervisors are responsible for completing and submitting this form WITHIN 24 HOURS of first notice of an employee's injury. All items must be completed in order to properly process this form. Distribute the copies as noted on the bottom of this form. This information is critical to the injured employee's claim for benefits. DO NOT DELAY. This form must be completed even if the employee did not receive medical attention or if the injury seems minor. If you have questions, please call one of the following numbers:

CAMPUS EMPLOYEE: Office of Insurance & Risk Management..... 794-6952; 794-6948 / Fax: 794-6957

Date: _____

Check One: Campus Employee Volunteer Student

- 1. Name _____ Social Security Number _____
2. Home Address _____ City _____ Zip _____
3. Male Female Home Telephone _____
4. Department _____ Job Title _____ Campus Extension _____
5. Job Status: Full Time Part Time Temporary
6. Date of Injury _____ Time of Injury (am/pm) _____ Date Reported _____
7. Nature of Injury (sprain, contusion, etc.) _____ Part of Body Affected _____
8. What was employee doing when injured? _____
9. How did the injury occur? Please describe in detail. _____

- 11. Name and contact number of the person that this injury was reported to _____
12. Supervisor's Name (PLEASE PRINT) _____ Extension _____

INVESTIGATION OF ACCIDENT (TO BE FILLED OUT BY SUPERVISOR)

- 13. Time employee began work (exact hour) _____ (am/pm). Did employee lose time off due to injury? _____
14. Date last worked _____ Date returned to work _____
15. Was the employee paid full wages for the day of injury or last day worked? _____
16. Location of Accident (Building, Room #, Floor, Corridor, etc.) _____
17. Were there materials or equipment associated with the injury? _____
18. Were there any witnesses? _____
19. Injury evaluated by: Emergency Room Occupational Health Other (please specify) _____
20. Was employee exposed to blood/bodily fluid other than his/her own? _____ If yes, write their name, address and contact number _____
23. Comments _____

RETURN TO WORK (RTW) OHF/ER TO COMPLETE

- 1. Can immediately RTW Yes No Date _____
2. Can RTW with these restrictions: _____
3. Estimated period of absence _____
4. Next scheduled visit _____
5. Medical Provider Signature _____

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Distribution: Campus: 1. Occupational Health/ER 2. Insurance & Risk Management 3. Employee's File 4. Professional Risk Management