LEWIS UNIVERSITY

EMPLOYEE'S REPORT OF INJURY

INFORMATION ABOUT YOU
Name: *Home Phone # :*
SS#: *Date of Birth:*
Date of Hire: *Department:* *Job Title:*
Home Address:
City: *State:* *ZIP:*
INFORMATION ABOUT THE ACCIDENT
Date of Accident: *Time of Accident:*
Place of Accident:
What were you doing before the accident?
What happened?
Witnesses, if any:
Who were you working with at the time of the injury:
Who did you report the injury to:
What date did you report the injury:
INFORMATION ABOUT THE INJURY
What part of your body was injured:
Any other part(s) injured:
What kind of injury (sprain, cut, broken bone):
Marital Status: ***M*** ***S*** *Dependents under 18 years of age:*
Average weekly wage: (HR Use Only)
INFORMATION ABOUT TREATMENT

Treating physician:
Address:
Phone Number:
Clinic Treating You:
Address:
Phone Number:
Type of Treatment (medication, heat treatment, etc.):
Has the doctor taken you off work? (please circle) YES NO
Please ask your doctor to contract Human Resources regarding any work restrictions you have been given.
GENERAL INFORMATION
Any previous injury to the same part of your body?
Explain:
Have you understood all the questions you have answered? ❑ ***YES*** ❑ ***NO***
*I give my permission to have this form and any other pertinent medical information **FAXED** to The Christian Brothers Benefit Trust Workers' Compensation Unit:* ❑ ***YES*** ❑ ***NO***
***EMPLOYEE SIGNATURE**:*
DATE:

UNIT HEAD

SIGNED: _____

DATE: _____

OFFICE OF HUMAN RESOURCES

SIGNED: _____

DATE: _____

(Office of Human Resources / 09-01-10)