

INDIANA UNIVERSITY OCCUPATIONAL INJURY ILLNESS REPORT USB IUNW IUK IUE IUSE
 (SELECT ONE)
 ALL ITEMS MUST BE FILED IN (OR MARKED N/A) OR FORM WILL BE RETURNED TO YOU!

File _____

Employee name _____ Last name _____ First name _____ M.I. _____
 Address _____

Social Security Number _____ Sex _____ Home phone _____

DOB ____/____/____ Height _____ Weight _____ **ASK THEM** Work phone _____

Date of accident ____/____/____ Time ____:____ AM PM

Reported to supervisor: Date ____/____/____ Time ____:____ AM PM

Returned to work ____/____/____ Regular work schedule (ex: M - F) _____

Total days lost ____ Days *1* _____ Wage rate \$ _____ H / B-W / M

Payroll Clerk _____ Last name _____ First name _____ H.I. _____ Telephone _____

Department _____

Foreman _____ Last name _____ First name _____ H.I. _____ Accl. # _____

Hours worked day of injury ____ Employment date/U ____/____/____

Employment date/this job ____/____/____

Job Classification (ex: Dishwasher, not SHOI) _____

Exact place of accident _____

Nature & Extent of injury _____ (use back of form, if necessary)

Treated by Dr. _____ Date ____/____/____

Treated at Hospital/Clinic _____

Was a safety device provided? Yes No Was it used? Yes No

Was a safety regulation violated? Yes No

Was a tool involved? Yes No Part of tool _____

Type of power (ex: electric) _____

If an object was being lifted or carried - approx. weight _____

If you have any recommendation about how to avoid future accidents like this, safety devices that should be used, or wish to propose any safety regulations, do so on the back of this sheet or at the end of the description of accident.

Date of this report ____/____/____ Employee signature _____

I HEREBY CERTIFY THE ABOVE IS A TRUE AND ACCURATE DESCRIPTION OF MY ACCIDENT.

Supervisor's signature _____ THE EMPLOYER AND SUPERVISOR MUST BOTH SIGN THIS FORM

Department head _____

Question? Call Lynn Sinn, Joyce Couch or Teresa Ryora at 855-4847.

LOST _____ OSHA _____ RESTRICTED _____ DISEASE _____

DESCRIPTION OF ACCIDENT

[Give a complete description. Were there witnesses? Give names, telephone numbers. What did they see? What caused the accident?]

Witnesses (and telephone/address) _____

1. Return this form to Office of Risk Management, Bloomington.
2. Employee must sign the authorization release on other side of this form.
3. If the accident involves exposure to human tissue, blood, or fluid, the employee is required to take (in person) one copy of this form to the nearest Hospital Emergency Room within 24 hours of exposure. If a sample of the source of contamination can be obtained, take the sample with you for testing. Send a copy of this form to the Risk Officer-Biosafety, Bryan Hall 110, IUB.
4. Payroll clerk is responsible for reporting all lost time to Risk Management.

AUTHORIZATION FOR MEDICAL RECORDS

This will authorize you to disclose to Indiana University Human Resource Services Worker's Compensation Services or it's representatives, information you may have regarding my condition while under your observation or treatment at any time, including medical history and findings, consultation, prescriptions, treatment, x-ray, special consultation reports, diagnosis and prognosis, and copies of all hospital and medical records.

A photo static copy of this Authorization shall be considered as effective and valid as the original.

GINA Notification to Health Care Providers:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or receive genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature _____

Address _____

City _____ State _____ Zip _____

DOB _____

Date _____