INDIANA UNIVERSITY OCCUPATIONAL INJURY/ILLNESS REPORT

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. Please fax completed report to IU Workers' Compensation: **812/855-2720**.

Employee Name: _____ **IU Campus:** _____

Employee ID: _____ **Gender:** _____ **Height:** _____ **Weight:** _____ **DOB:** _____

Home Phone: _____ **Business Phone:** _____

Date of Accident: _____ **Time of Accident:** _____ AM ☐ PM ☐

Reported to Supervisor; Date: _____ **Time Reported:** _____ AM ☐ PM ☐

Payroll Clerk: _____ **P/R Clerk's Phone Number:** _____

Department: _____ **Foreman/Supervisor:** _____

Injured Employee's Regular Work Schedule :(Example; 8-5, m-f) _____ **Pay :** Hourly ☐ Bi-Weekly ☐Monthly ☐

Employment Date for this Job: _____ **Treated by DR.**_____

Job Title: _____ **Treated at Hospital/Clinic**_____

Exact Place of Accident: _____

Nature and Extent of Injury: (Example; sprain left ankle, cut right 3rd finger, etc.) _____

Description of Accident: _____

_____

_____

_____

Witnesses, if any: _____

Date Completed: _____ **Employee's Signature:** _____

Supervisor's Signature: _____

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 _____