

# 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 contact 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: \_\_\_\_\_