Lincoln Memorial University

EMPLOYEE INJURY REPORT FORM

Instructions to Employee:

- Employees are **required** to immediately report to their supervisor any workplace incident involving the employee (accident, exposure to chemical, etc.) regardless of whether the incident results in injury.
- Fill out this form, completing **all** sections, sign, and date it.
- Ensure your Supervisor signs and dates the bottom of the form.
- Submit the form to Human Resources immediately following the incident (within 24 hours) humanresources@LMUnet.edu
- If Employee is unable to complete this document, their direct supervisor is responsible for completing the steps above.

EMPLOYEE'S INFORMATION

Employee Name:		Department:	
LMU ID #:	Date of Birth:	Age:	Male ☐ Female ☐
Address: (Address/ P.O Box, City, ST ZIP Code)			
Email address:	Home Phone:	Cell Phone:	
Witness:	Phone #:	Email:	

Incident Report

Campus where Incident Occurred:	Date of Incident: (mm/dd/yy)	Time of Incident: (AM/PM)	Time employee began university business on date of Incident: (AM/PM)
Exact Location of Incident: (parking lot, elevator, stairwell, etc.)		Type of Incident: (Indicate all applicable)	☐ Unsafe Conditions
Bldg. Name		☐ Fall	☐ Incident/Near Miss
Room #		☐ Cut/Abrasion	☐ Other (Describe:
		☐ Exposure to Chemical	

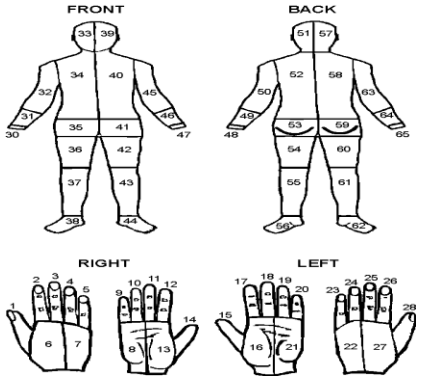
Police Department Contacted?: ☐ No ☐ Yes (If yes, indicate department)	Police Incident Report #:

Description of Incident: (use second page if needed)

Describe any property damaged:

If injury resulted, describe the nature of Injury or Illness (fracture, cut, allergic reaction, etc.):

Please indicate the area(s) of the body injured by coloring in the area on the diagrams to the right.



Medical Treatment Required?: ☐ No ☐ Yes (if yes please indicate) ☐First Aid Only ☐ Doctor/Clinic ☐ Emergency Room ☐ Other:	Date of First Treatment: Place of Treatment:

Type of Medical Treatment			
☐ No treatment required	☐ Foreign Object Removed	☐ Suture	☐ Referred for further treatment
☐ Prescription Medicine	☐ Hospitalization	☐ Splint or Cast	
☐ Other: (Describe treatment, use second page if needed)			

Time lost from work beyond day of incident: ☐ Yes ☐ No	Released to return to work: ☐ No ☐ Yes	If yes, please indicate: ☐ Follow-Up Visit to be Scheduled ☐ At Full Duty ☐ With Restrictions (Must Provide Documentation of Restrictions)

Indicate what object or substance directly harmed the employee:
(If nothing applies, put N/A)

If the employee died, when did the death occur? Date of Death:

Supervisor Comments	

Employee or Person Completing Report (Print Name)

Supervisor (Print Name)

Signature Date

Signature Date

For Office of Human Resources Use ONLY	Report received from: Date Report Received: Identifier #: