SHARED SERVICES CONSORTIUM
EMPLOYEE INJURY REPORT
FAX: 800-706-9344 / PHONE: 800-641-6330

*Date of Injury (day xx/xx/xx) *Time of Injury

*Work Schedule on Date of Injury

Employer

*Employee Name: First MI Last

Employee Social Security Number

*Employee Date of Birth

*Home Address

*City, State, Zip code

County

Home Phone

Work Phone

Fax and/or e-mail address (optional)

*Job Title

Employee:
☐ *Male ☐ Single
☐ *Female ☐ Married

PA
State in which employee was hired

Department

Number of Dependents

Status (Part-time, full-time, student, IC, Seasonal)

Hourly/Salary wage if known *Date Hired

Supervisor

Normal Work Schedule

Work Location/Department (as defined by UCIC)

*What Was Employee Doing When Incident Occurred?

*What Happened?

*What was the Injury or Illness?

*What Object or Substance, if any directly harmed the employee?

Witness Name and Phone Number:

*Fatal Injury? ☐ **Yes** ☐ **No** (If Fatal) *List Date of Death

Date of Disability (First day missed work)

Return to Work Date

Full Pay for Date of Injury? ☐ **Yes** ☐ **No**

Was Safety Equipment Provided? ☐ **Yes** ☐ **No**

Was Safety Equipment Used? ☐ **Yes** ☐ **No**

*NATURE OF INJURY

- ☐ Abrasion
- ☐ Amputation
- ☐ Bruise
- ☐ Burn chemical
- ☐ Burn thermal
- ☐ Carpal tunnel
- ☐ Contusion
- ☐ Cut/laceration
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Electrical shock
- ☐ Eye Injury
- ☐ Fracture
- ☐ Hernia
- ☐ Infection
- ☐ Irritation joint or muscle
- ☐ Other: _____
- ☐ Puncture wound
- ☐ Sprain / Strain

*BODY PART

- ☐ Abdomen
- ☐ Ankle L ☐ R ☐
- ☐ Arm: upper L ☐ R ☐
- ☐ Back Upper ☐ Middle ☐ Lower ☐
- ☐ Chest
- ☐ Elbow L ☐ R ☐
- ☐ Finger L ☐ R ☐
- ☐ Foot L ☐ R ☐
- ☐ Forearm L ☐ R ☐
- ☐ Groin
- ☐ Hand L ☐ R ☐
- ☐ Other: _____
- ☐ Head / Face
- ☐ Hip L ☐ R ☐
- ☐ Knee L ☐ R ☐
- ☐ Leg L ☐ R ☐
- ☐ Multiple: _____
- ☐ Neck
- ☐ Shoulder L ☐ R ☐
- ☐ Thigh L ☐ R ☐
- ☐ Thumb L ☐ R ☐
- ☐ Toe(s) L ☐ R ☐
- ☐ Wrist L ☐ R ☐

TREATMENT

- ☐ No medical treatment
- ☐ Minor by employee
- ☐ Clinic / Hospital
- ☐ Panel Physician
- ☐ Employee Physician
- ☐ *Emergency care
- ☐ *Hospitalized more than 24 hrs.

NAME OF PHYSICIAN/MEDICAL CENTER ETC.

*Name of physician/facility or other medical professional providing care

*Address

*City *State *Zip Code Phone/Fax Numbers

Date and Time Employer Notified To Whom:

*Name and Title of person completing report *Phone Number/Fax Number *Date report completed

Injured Employee Signature Date

*Equivalent information asked on OSHA forms *(complete where applicable)*