

YALE UNIVERSITY EMPLOYEE FIRST REPORT OF INJURY

Send Original To: Office of Workers Compensation, 55 Whitney Avenue, Suite 470 or Fax 432-5432

Send Copies to UHS 55 Whitney Avenue and OEHS, 135 College Street

Maintain a Copy in Department Files

Date Prepared:			
Prepared By:	<u>Name</u>	<u>Department</u>	<u>Telephone Number</u>

PERSONAL DATA

Injured Employee:	<u>Last Name</u>	<u>First Name</u>	<u>Middle Initial</u>
Home Address:			
Home Telephone Number:			
Work Telephone/Cellular Telephone Number:			
Date of Birth:	Gender:	Yale UPI:	

JOB INFORMATION

Position/Job Title:	Department Name:
Employee's Regular Work Schedule:	
Immediate Supervisor's Name:	Fax Number:
Supervisor's Telephone and Cellular Telephone Numbers:	

ACCIDENT/INJURY DETAILS

Date of Injury:	Time of Injury:	AM/PM
Accident Location (Building Name or Address):		
Date Reported to Supervisor:		
Did Employee Report Injury to Supervisor?		
If no, how was supervisor notified?		
Describe the Sequence of Events Leading Up to the Injury. What was the employee doing at the time and what happened?		
Identify any equipment, tools, or other materials, if any, the employee was using which may have contributed to the injury:		
Describe Injured body part (left elbow, right knee) and type of injury (abrasion, sprain, fracture, etc.):		
Names, Addresses and Telephone Numbers of Witnesses:		

MEDICAL INFORMATION

Date of Initial Treatment:
Diagnosis (if known):
Initial Treatment Location: Employee Health _____ Urgent Visit _____ Private Physician _____ Hospital _____
If Private Physician, please provide Name, Telephone Number and Address:
If Hospital, please provide name of Hospital:

WORK STATUS

Has injured employee returned to work? Y/N	Is the employee on modified duty? Y/N
Date and Time of Return to Work:	

Signature of Immediate Supervisor:	Date:
Signature of Department Head:	Date: