Plymouth State University

Report of Injury/Occupational Illness

Important: This report must be filled with the appropriate camp-us office within two (2) days of the date of injury/illness

HR USE: USNH ID#_____

IMPORTANT INFORMATION TO BE COMPLETED BY EMPLOYEE

Name | Social Sec. # | Date of Birth

Home Address | Department | Dept. Phone

City/State/Zip | Home Phone

Date of injury/illness | Day of week | Time

Hours worked/day | Days worked/week | Occupation

Annual rate | Hourly rate | Date of Hire

Describe fully how injury/illness occurred and indicate what person was doing when injury/illness occurred:

Nature and specific location of injury:

Probable length of disability:

Where did injury occur?

Witness(es)

Did you seek medical treatment?

If yes, Where:

Signature of person reporting injury/illness

IMPORTANT INFORMATION TO BE COMPLETED BY SUPERVISOR OR APPROPRIATE CAMPUS OFFICIAL

Lost Time:

If yes, beginning date:

Has injured returned to work?

If yes, date returned:

Date injury/illness reported to supervisor or campus official:

Describe results of the accident investigation:

Name of supervisor or campus official (print)

Signature of supervisor or campus official

Date