Plymouth State University

Report of Injury/Occupational Illness

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

IMPORTANT INFORMATION TO BE COMPLETED BY EMPLOYEE

Name

USNH ID #

Date of Birth

Phone Number

Dept. Phone

Hours Worked/Day

Department

Occupation

Date of Injury/Illness

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

Nature and specific location of injury:

Where did injury occur (on campus)?

Witness Name(s), Contact Information:

Did you seek medical treatment?

If yes, please specify name of hospital and/or name of Doctor with contact information:

Signature of person reporting injury/illness:

IMPORTANT INFORMATION TO BE COMPLETED BY SUPERVISOR OR APPROPRIATE CAMPUS OFFICIAL

Has injured employee lost time?

If yes, beginning date:

Has injured employee 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

Signature of supervisor or campus official

Date