University of Baltimore

Employee's Report of Injury/Occupational Illness

(Please complete this form and give to your supervisor within 24 hours of the incident)

PLEASE PRINT LEGIBLY

Employee's Name: ____SSN: _____- ____-____ ☐ Male

Last First Middle ☐ Female

Date of Birth: ____/ ____/ ____ Home Phone # ( ) ______________Work Phone # ( )____________

Home Address: ____

City, State, Zip code: ____

Present Job title: _________________________Department: ________________Date of Hire: __________

Marital Status: __________________________________Number of Dependents: _____________________

Date of Injury/Illness: ________________________ Time of Injury/Illness__________________________

Time workday began: ___________________________ Rate of Pay $________________ Bi-weekly/hourly

Location where incident occurred:____

Building Area (hallway etc.)

Describe in detail how Injury/Illness occurred: ____

____

____

____

(continue on other side, if necessary)

Describe bodily injury sustained (be specific about body part (s) affected:____________________________

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____

____

(continue on other side, if necessary)

Name (s) of Witness (es): ____

Recommendations on how to prevent this injury/Illness from recurring: _____________________________

____

Name of Supervisor: ____

Last First Middle

Date & Time reported the injury/illness to your supervisor ____

Signature of Employee: _____________________________________ Date: _______________________