University of Baltimore

Supervisor's Report of Injury/Occupational Illness

(Please complete this form and return original to HR along with original of Employees Report within 48 hours of the incident)

PLEASE PRINT LEGIBLY

Carrier: INJURED WORKERS INSURANCE FUND (IWIF) Policy#: 902969 **Claim #**______________
(HR will complete)

Injured Employee ____SS#: ____________________
Last First Middle

Employment Status: Regular ____ Contingent ____ Student ______ Department__________________________

Date of Injury/Illness______________ Time of injury/illness_________ Time Workday Began:__________a.m/p.m.

Date when you were notified of the injury/illness?____

Location where incident occurred: ____
Building Area (hallway, etc.)

Describe in detail how injury/illness occurred: ____

____

____

(describe the work-process the employee was engaged in, give the purpose of the function or task, describe how the injury occurred, and explain the cause)

(Attach additional sheet if necessary)

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

____

(Attach additional sheet if necessary)

Do you agree with the employee's version of the incident: Yes_______ No________

If no, explain:____

____

(Attach additional sheet if necessary)

Medical Attention Given? Yes____ No____ By Whom?____
(Name & Address)

Was employee paid full pay for day of injury/illness? Yes_____ No_____

Any lost time? Yes______ No______ How much?________________

Has employee returned to work? Yes____ No_____ If yes, Full Duty:_____ Modified Duty:____________

If modified duty, for how many days?_____________

Comments:____

____

Name of Supervisor: ______________________________Position:_______________Work Phone #: __________

Signature of Supervisor: ____ Date:__________________