

Colorado State University Incident Report or Worker's Compensation Report

(See Instructions on Back of This Form)

Mark if this is an Incident Report or a Workers' Comp claim: Incident Report () Workers' Comp ()

This form is needed when an employee is injured while in the course of employment. Employee should complete Part I & II in full; Supervisor should complete and sign Part III. If employee is not able to complete form, supervisor should do so. Submit to Environmental Health Services (department 6021), 141 General Services Building, within four days of injury.

| Part I - EMPLOYEE MUST COMPLETE THIS SECTION OF THE REPORT | | | | | | | | | | |
|--|--|--|--|---|------------------------------|---|-------------------------------------|--|-----------|--|
| Employee's Name (First, Middle, Last) | | | | | Sex | | Home Phone No | | | |
| Employee's Street Address | | | | | City | | State | Zip | Job Title | |
| Marital Status | | | Primary Language - English () Spanish () Other () | | | | | CSU Health Insurance None () Your Policy () Spouse Policy () | | |
| Wages: a) Hourly _____ (if paid hourly) OR b) Weekly _____ (if salaried) | | | | | | | Course Name & No. if Student Intern | | | |
| Employment Classification: a) Fac or AdminPro () b) State Classified () c) Non-Student Hourly () d) Work Study () e) Student Hourly () f) Student Intern () g) Graduate Student () h) Other () Specify- | | | | | | | | | | |
| Part II - INJURY INFORMATION - EMPLOYEE MUST COMPLETE THIS SECTION OF THE REPORT | | | | | | | | | | |
| Injury Date (mo/day/yr) / / | | | | Time of Injury (hr:min) _____ : _____ AM () PM () | | | | | | |
| What happened to cause this injury or illness? Describe employee's activities when injury or illness occurred with details of how event or exposure occurred; include name(s) of other individuals involved, tools, machinery, objects, vapors, chemicals, radiation, unnatural motions of employee, unsafe/hazardous conditions, etc. Also specify the items which directly injured the employee and caused the accident or illness. (If additional space is needed, use back of this form) | | | | | | | | | | |
| Injury Description (State exactly the part(s) of the body affected and the nature of the injury or disease) | | | | | | | | | | |
| Name of Witnesses | | | | | | | | | | |
| Name of employer representative notified | | | | | | | | | | |
| Place of accident/exposure (Bldg. Name and Room Number), City, County, State, Zip Code | | | | | | | | | | |
| Treatment received: 911 called () Emergency Room () Minor-Clinic () Admitted to Hospital () Surgery () Incident Report Only () | | | | | | | | | | |
| Name & Address of Treating Doctor and/or Hospital | | | | | | | | | | |
| Employee Signature: | | | | | | | Date: | | | |
| Part III - SUPERVISOR MUST COMPLETE THIS SECTION OF THE REPORT | | | | | | | | | | |
| Employee's normal schedule: _____ hrs/day, _____ days/week Shift Start/End time: _____ / _____ Was employee on this schedule when injured Y () N () | | | | | | | | | | |
| Last Day Worked: / / 28 | | | Date returned to work: / / | | | OR Estimated date of return: / / | | | | |
| Modified work available: Y () N () If NO, Why? | | | | | | Did injury cause death Y () N () Date of death: / / | | | | |
| If death, Name, relationship, and address of closest dependent | | | | | | | | | | |
| Auto Accident () Possible Drug/Alcohol Violation () Possible Safety Violation () Employer Questions Liability () | | | | | | | | | | |
| If Employee is State Classified, at time of injury the Sick Leave Balance is: | | | | | the Annual leave balance is: | | | | | |
| Department & work unit | | | | | | | | | | |
| Supervisor Printed Name | | | | | | | Supervisor Phone | | | |
| Supervisor Signature | | | | | | | Date | | | |