

Illness or Injury Report Form

- Non-Work Related Illness or Injury Contract Worker (non U of M payroll)
 Work Related Illness or Injury Work-related illness/injury
 Certification of Medical Condition Only (for MIOSHA reporting purposes only)

Please type or print with black ink. Fax form immediately to (734) 936-1913.
 State law requires the employer to provide medical care at a designated medical facility. Within the first 10 days the employee is required to treat at the employer's dedicated medical facility. If you need the name of a designated medical facility, call WorkConnections. For serious incidents, please call WorkConnections immediately. Complete and submit this form within 24 hours of notification of injury.

Faculty or Staff Member Information. Complete this section for ALL illnesses or injuries			Please print or type in black ink.
Faculty or Staff Member Name (Last, First, Middle Initial)		Today's Date	
Home Street Address		Employee I.D. Number (U-M I.D.#)	
City	State	Zip + 4 digits	
Social Security Number (mandatory for work-related incidents)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	
Home Phone Number (include area code)	Work Phone Number	Date of Hire	
Department Name <u>and</u> Department Code	Occupation	Employment <input type="checkbox"/> Regular <input type="checkbox"/> Temporary	
Supervisor's Name (please print)	Supervisor's Phone Number	Supervisor's Pager Number	
Was this person out of work due to the illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has this person returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, give dates:	Were there restrictions on the work he or she could do? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Last Date Worked _____	Date Returned to Work _____	If yes, describe	
What happened to cause injury or illness?		Have those restrictions been accommodated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Scheduled Workdays (Check) <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU <input type="checkbox"/> Day <input type="checkbox"/> Afternoon <input type="checkbox"/> Midnights	
Injury/Incident Information. Complete this section only for Work Related illness or injury			
When did the incident occur or the illness begin?	Name of Witness _____		
Date _____ Time _____ A.M. P.M.	Phone Number _____		
When did the employee first report the incident or illness to the department?	Who was it reported to? _____		
Date _____ Time _____ A.M. P.M.	Title _____		
	Phone Number _____		
Location of incident (be specific)	Did incident involve a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Nature of injury or illness (for example: contusion, burn, strain)	Part of body directly affected by the injury or illness (for example: hand, arm, circulatory system)		
Describe the events which caused the injury or illness (for example: fall, puncture, chemical exposure)	Name of object or substance which directly injured the employee (for example: knife, needle, patient)		
Treating Facility (check one): <input type="checkbox"/> MWorks <input type="checkbox"/> EHS <input type="checkbox"/> ER Other _____	Was treatment declined? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Briefly Describe Treatment	Describe actions taken by supervisor to prevent recurrence of this incident		
Supervisor's Signature _____ Date _____ Fax _____			