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Phone: (734) 615-0643 Toll-free: (877) 869-5266 Fax: (734) 936-1913

E-mail: Work.Connections@umich.edu Website: workconnections.umich.edu

## **Illness or Injury Report Form**

Non-Work Related Illness or Injury	Contract Worker (non U-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 Work Connections. For serious incidents, please call Work Connections 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	☐ Female ☐ Male
Home Phone Number (include area code)	Work Phone Number	Date of Hire
Department Name and Department Code	Occupation	Employment
Supervisor's Name (please print)	Supervisor's Phone Number	Supervisor's E-mail
Was this person out of work due to the illness or injury? ☐ Yes ☐ No If yes, give dates:	Has this person returned to work? ☐ Yes ☐ No  Were there restrictions on the work he or she could do? ☐ Yes ☐ No  If yes, describe	
Last Date Worked Date Returned to Work	Have those restrictions been accomodated	?    Yes    No
What happened to cause injury or illness?	Ŋ	eduled Workdays (Circle) /I T W TH F SA SU t: Day Afternoon Midnight (circle)
Injury/Incident Information. Complete this section only for work-related illness or injury.  Please print or type in black ink		
When did the incident occur or the illness begin?	Name of Witness	
DateTime PM	Phone Number	
When did the employee first report the incident or illness to the department?	Who was it reported to?	
AM Date Time PM	Phone Number	
Location of incident (be specific)	Did incident involve a motor vehicle?	Yes 🗆 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	Was treatment declined? ☐ Yes ☐	No
Briefly Describe Treatment	Describe actions taken by supervisor to pre	vent recurrence of this incident
Supervisor's Signature Date		