WORK CONNECTIONS
UNIVERSITY OF MICHIGAN

Illness and Injury Assistance

G300 Wolverine Tower
3003 South State Street
Ann Arbor, MI 48109-1269

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
☐ Work Related Illness or Injury
☐ Certification of Medical Condition Only
☐ Contract Worker (non U-M payroll) Work-related illness/injury (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 28 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 ☐ Regular ☐ Temporary
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:

____________ Last Date Worked ____________ Date Returned to Work

Has this person returned to work? ☐ Yes ☐ No
Were there restrictions on the work he or she could do? ☐ Yes ☐ No
If yes, describe ____________________
Have those restrictions been accomodated? ☐ Yes ☐ No

What happened to cause injury or illness?

Scheduled Workdays (Circle)
M T W TH F SA SU
Shift: 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?
Date ____________ Time ________ AM PM

When did the employee first report the incident or illness to the department?
Date ____________ Time ________ AM PM

Name of Witness ________________
Phone Number ________________
Who was it reported to? ________________
Title ________________
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 prevent recurrence of this incident
Supervisor's Signature ____________ Date ______	

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