Higher Education Consortium of Metropolitan St. Louis

INJURY REPORT

THIS REPORT MUST BE COMPLETED WITHIN 24 HOURS AFTER THE INJURY

WHO WAS INJURED?

Name: _____ Employee ID: _____
Job Title: _____ Supervisor: _____

WHEN DID THIS INJURY HAPPEN?

Date of injury: _____ Time: _____ Location: _____

Task being performed: _____

WHAT HAPPENED?

Accident Description. Please provide an objective chronology of the incident (attach additional sheet if needed):

Name of witness(es) to accident:

Describe the injury (include body parts involved):

Injury Classification: (Check only one)

☐ First Aid (first aid administered one time)
☐ Medical Aid (treated by a physician)
☐ None
☐ Lost of time accident (could not report for work neither after the accident nor at next regularly scheduled time.)

If employee treated at a medical facility, list facility and address:

HOW CAN WE PREVENT THIS ACCIDENT FROM HAPPENING AGAIN? (add additional sheet if needed)

Signature of Supervisor: _____ Date: _____

Comments by injured employee:

Employee Signature: _____ Date: _____