Report of Injury

NAME (Last, First, Middle) : SOCIAL SECURITY NO:

RESIDENTIAL ADDRESS (Street Address, City, State, Zip) TELEPHONE NO(S).

DATE OF INJURY: TIME OF INJURY: □ A.M. □ P.M. WORK START TIME: □ A.M. □ P.M.

Accident Reported to (name & title):

Witnesses: Full Name Address (Street, City, State, Zip) Telephone No.
1.

2.

Treating Physician: Full Name Address

Hospital (if hospitalized): Full Name Address

DESCRIPTION OF ALLEGED INJURY–WHAT ITEM CAUSED THE INJURY, BODY PART, AND EVENTS LEADING UP TO AND INCLUDING THE INJURY (PLEASE ATTACH A SECOND PAGE IF NECESSARY):

EXACT LOCATION AND/OR BLDG (including floor, room, etc.):_____

Birthdate (mm/dd/yy) Sex: □ Female □ Male

****Employees MUST also complete the following / Injured Students only complete above this line****

Tax Filing Status (circle one): Single, Single, Head of Household, Married, Filing Jointly, Married, Filing Separately, □ If married, spouse is supported at least 50% by injured.

No. of Dependent (under age 16) : _____ Other family members supported at least 50% by injured (specify on line below):

Lost Day(s) Due to Injury: □ Yes □ No Date of Last Day Worked: Date returned to work/ estimated length of disability:

Your Classification Your Department # of Hours Worked Per Week: DATE OF HIRE:

Do you have a SECOND EMPLOYER?: □ Yes □ No: If yes, Company Name and Complete Address:

Public Safety Contacted: □ Yes □ No Case # _____

I Am Currently Enrolled As A Medicare (Not Medicaid) Beneficiary: □ No □ Yes, HCN# _____

Your WSU Supervisor's Complete Name, Phone Number and E-mail Address:

Your Complete Campus Address & Campus Phone:

Employee'/Student Signature/Date:

Supervisor's Signature/Date:

INSTRUCTIONS:
ALL INFORMATION MUST BE COMPLETED AND BOTH SIGNATURES OBTAINED FOR EMPLOYEE INJURIES
SUBMIT WITHIN 24 HOURS TO WAYNE STATE UNIVERSITY OFFICE OF RISK MANAGEMENT
5700 Cass Ave., Suite 4622, Detroit, MI 48202