BALDWIN WALLACE UNIVERSITY
INJURY REPORT FORM
(To be filed within 24 hours of occurrence)

Name _____ Soc Sec # _____
Last First Middle

Student _____ Student Worker _____ Employee _____ FT _____ PT _____ Visitor _____

What days of the week do you usually work? # of Hours _____

_____ Sun _____ Mon _____ Tues _____ Wed _____ Thur _____ Fri _____ Sat

_____
Home Address Street City State County

Home Phone (with Area Code) _____ Date of Birth _____

Age _____ Sex _____ Marital Status _____ Hire Date _____

Department Name _____ Job Title _____

Date of Injury _____ Time of Injury _____ Date reported to employee _____

Where did injury occur? _____

Describe accident in detail: _____
_____
_____

Type of injury and part of body involved: _____

Treatment By: _____ First Aid _____ Doctor _____ Health Center _____ Hospital

Name of Doctor: _____ Name of Hospital _____

Will injury cause loss of time? _____ For How Long? _____

When is employee expected to return to work? _____

Names of any witnesses: _____

What has been done to prevent a recurrence? _____

_____
Employees Signature & Date Job Title

_____
Supervisor's Signature & Date Title

Routing: Non-working students and visitors > Purchasing / All employees and student workers > Human Resources