

**INITIAL REPORT ON WORK-RELATED INJURY or ILLNESS**

This report must be completed and signed by the employee immediately, but no later than 24 hours, after an occupational/work-related injury or illness. The supervisor must sign and forward the report immediately after an employee submits the report. If the employee is not available to complete the report, the supervisor must complete the report for the employee.

This form is not an insurance form. Cases listed below are not necessarily eligible for Worker's Compensation or other insurance. Listing a case below does not necessarily mean that the employer or the worker was at fault or that an OSHA Standard was violated.

**TYPE OR PRINT IN INK. ATTACH ADDITIONAL PAGES IF YOU NEED EXTRA SPACE.**

1. Has a fatality occurred?  No  Yes If yes, date of death (mo./day/yr.) \_\_\_/\_\_\_/\_\_\_

2. Employee Name (last, first, middle) \_\_\_\_\_

3. Date of Birth (mo./day/yr.) \_\_\_/\_\_\_/\_\_\_

4.  Female  Male

5. UCID number  M

6. Date Hired (mo./day/yr.) \_\_\_/\_\_\_/\_\_\_

7. Home Address (# and street, city, state, and zip code) \_\_\_\_\_

8. Home Phone ( ) \_\_\_\_\_

9. Job Title \_\_\_\_\_

10. Dept. Phone ( ) \_\_\_\_\_

11. Department \_\_\_\_\_

12. Time employee began work  a.m.  p.m.

13. Date of injury or illness (mo./day/yr.) \_\_\_/\_\_\_/\_\_\_

14. Time of injury or illness  a.m.  p.m.

15. Was employee on duty at the time?  Yes  No

16. Is this a new injury or illness?  Yes  No

17. Did injury or illness occur on UC premises?  Yes  No

18. Location of Incident (Building & Rm.) \_\_\_\_\_

19. Name(s) and Phone(s) of Witness(es) \_\_\_\_\_  No Witnesses

20. Name of Supervisor Notified \_\_\_\_\_ Date & Time Notified \_\_\_\_\_

21. Did employee receive medical treatment following this incident?  Yes  No

22. Medical Facility (name, phone, and address) \_\_\_\_\_ Date of Treatment \_\_\_\_\_

23. Name of physician/health care professional \_\_\_\_\_

24. Was employee treated in an emergency room?  Yes  No

25. Was employee hospitalized overnight as an in-patient?  Yes  No

26. Check Part(s) of Body Affected and circle Right/Left

<input type="checkbox"/> Head (R / L)	<input type="checkbox"/> Face and Neck (R / L)	<input type="checkbox"/> Eye (R / L)	<input type="checkbox"/> Trunk/Internal Organs (R / L)
<input type="checkbox"/> Arm (R / L)	<input type="checkbox"/> Hand (R / L)	<input type="checkbox"/> Leg (R / L)	<input type="checkbox"/> Feet (R / L)
<input type="checkbox"/> Upper Back (R / L)	<input type="checkbox"/> Lower Back (R / L)	<input type="checkbox"/> Other _____	

27. Check Specific Type of Injury or Illness

<input type="checkbox"/> Fracture	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Bruise	<input type="checkbox"/> Cut
<input type="checkbox"/> Burn	<input type="checkbox"/> Sprain or Strain	<input type="checkbox"/> Other _____	

28. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key entry."

29. What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

30. What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

31. Who completed this form?  Injured employee  Supervisor  Other \_\_\_\_\_

32. Date completed \_\_\_\_\_

I certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. Furthermore, I understand the information I supplied may be audited by the University or its representatives. I understand that falsifying this document may be grounds for disciplinary action up to and including termination of employment. In addition, I may be in violation of Federal and/or State laws and subject to prosecution.

33. \_\_\_\_\_  
Employee's Signature Date

I have reviewed this report and acknowledge its receipt.

34. \_\_\_\_\_  
Supervisor's Signature Date Phone number

<p><b>SEND REPORT TO:</b> Original - Environmental Health &amp; Safety, ML 0218 Copy - Retain in Departmental Business Office Fax - Human Resources, 513-558-0676 Copy - Provide to Employee</p>	<p><b>ENVIRONMENTAL HEALTH &amp; SAFETY OFFICE USE ONLY</b></p>	<p><b>FORM A-1352 (a) Rev. 03/20</b></p>
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