

CALVIN COLLEGE EMPLOYEE INJURY REPORT FORM

 FACULTY

 STAFF

 STUDENT WORKER

Employee Name	Job Title	Dept	Shift <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd
Home Address		City	State / Zip
Home Phone Number	Date of Birth	Date of Hire	Date of Occurrence Time of Occurrence <input type="checkbox"/> a.m. <input type="checkbox"/> p.m
Name of Witness(es)		Specific Location of incident (i.e., loading dock at north entrance of SB)	Social Security # (must have for filing comp claim)
			Date Reported to EHS or Supervisor

↓ Part of body affected (Indicate Left/Right, Front/Back, etc.)	Previous injury to affected body part? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, explain in detail
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Give all the facts by stating the job and situation involved. Include WHO, WHAT, WHY, WHERE, WHEN and HOW

↓ What were you doing when the Incident/Injury/Illness occurred and how did it happen? Be specific. List tools in use etc.

↓ What do you believe to be the cause of the incident/injury/illness?

↓ Specify any machine, tool, substance or object connected with incident/injury/illness

↓ If an injury or illness occurred, describe in detail. Include any and all symptoms you noticed (i.e. pain, redness, swelling) and when you first noticed them

↓ What can YOU do to prevent this incident/injury/illness from occurring again?

↓ What do you recommend to prevent a recurrence of a similar incident/injury/illness?

If you were using equipment/tools: were guards/safety devices/interlocks active or in use? Yes No Not required

Employee Statement

The facts stated above are true and correct to the best of my knowledge

Employee Signature

Date

Supervisor Signature

Date

Complete this form and send to EHS in the Physical Plant
If there are questions, call Heather Chapman at 526-8591

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