University of West Florida Employee Report of Injury

Section 1

To Be Completed By Employee

Print Form

Employee Information

Last Name: First Name: Middle Initial:

UWF ID: Date of Birth: Sex: Male Female

Employee's Position Type: Position Title:

Department Name:

Home Address:

Street: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Location of Incident: Campus Building Name:

Building Number: Room Number:

Date of Injury: Time of Injury: A.M P.M

Time Employee Began Work on Date of Injury: A.M P.M

What were you doing immediately before the injury occurred?

What happened?

Please go to the next page!

What was the resulting injury or illness?

What object or substance directly harmed you?

Would you like medical treatment? ◯ No ◯ Yes

If yes, Human Resources must be contacted prior to attaining medical treatment for non-life-threatening injuries. Call Human Resources at (850) 474 - 2606, 2156, or 2694.

Employee Signature: _____**Date**:_____

Section 2
To Be Completed By Supervisor

I have been made aware of this work injury.

Supervisor Signature:

_____ Date:_____

Print Supervisor Name:

_____ Phone:_____

This report must be forwarded to Human Resources, Building 20E, immediately upon the supervisor's review and signature.