University of West Florida Employee Report of Injury

Section 1
To be Completed by the Employee

Employee Information

Last Name: _____ First Name: _____ MI: _

UWF ID: _____ Date of Birth: _____ Sex: ◯ Male ◯ Female

Employee's Position Type: _____ Position Title: _____

Hire Date: _____

Department Name: _____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Work Phone: _____

Location of Incident

Campus Building Name: _____

Building Number: _____ Building Room Number: _____

Date of Injury: _____ Time of Injury (include AM or PM): _____

Time Employee Began Work on Date of Injury (include AM or PM): _____

What were you doing immediately before the injury occurred?

What happened?

Please continue to the next page.

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What was the injury or illness?

What object or substance directly harmed you?

Would you like medical treatment? ◯ No ◯ Yes

Employee Signature: _____ Date: _____

Section 2
To be Completed by the Supervisor

I have been made aware of this work injury.

Supervisor Signature: _____ Date: _____

Supervisor Name (Printed): _____

Supervisor Phone Number: _____

This report must be forwarded to Human Resources via email to hr@uwf.edu, immediately upon the supervisor's review and signature. Call Human Resources at 850.474.2694 or 850.972.9005 if you have any questions or concerns.

THIS SECTION FOR HR USE ONLY

Name of physician or other health care professional:

If treatment was given away from the worksite, where was it given?

Facility:

Street:

City: State: Zip:

Was employee treated in an emergency room? ○ Yes ○ No

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

Case number from Log:

If the employee died, when did death occur? Date of death:

Completed by:

Title:

Phone:

Date: