EMPLOYEE INCIDENT REPORT FORM (Form 5-WC)

Print Form

(To Be Completed by Employee and Supervisor Within 24 Hours of an Accident or Injury)
NOTE: No bills can be paid until we receive this form.

Today's Date: _____ **Employee ID Number:** 991 - ____ - _____

Employee Name: _____ **Job Title:** _____

Home Address: _____

Home/Cell Phone #: _____ **Date of Birth:** _____ **Date of Hire:** _____

Department Name: _____ **Department Org #:** _____

Department Phone #: _____ **Employee's Supervisor:** _____

Date of Incident: _____ **Time of Incident:** _____ ☐ AM ☐ PM

Location of Incident (building and area where injury occurred)**:** _____

Please explain your injury and how it happened: (i.e., lifting bed & sprained back; tripped over vacuum cord, fell & hit arm)

_____

Check Specific Type of Injury or Illness:

☐ Fracture ☐ Foreign Body ☐ Bruises ☐ Other: _____
☐ Burns ☐ Sprain or Strain ☐ Cut _____

Check Part(s) of Body Affected:

☐ Left ☐ Head ☐ Face and Neck ☐ Eyes ☐ Trunk
☐ Right ☐ Arms ☐ Hands ☐ Legs ☐ Other: _____
☐ Upper Back ☐ Lower Back ☐ Feet _____

List all equipment, materials, and chemicals the employee was using when the incident occurred:

_____

Did the employee go to the Center for Occupational Health for medical treatment? ☐ Yes ☐ No
Did the employee go to the hospital for emergency medical treatment? ☐ Yes ☐ No
Has the employee missed any time due to the injury? ☐ Yes ☐ No
If yes, please list dates and times missed: _____

Witness(es) to the incident? ☐ Yes ☐ No **If yes, please provide name(s) and phone number(s):**

_____

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 University or its representatives may audit the information I supplied. 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.

Employee Signature: _____ Date: _____
Supervisor Signature: _____ Date: _____
Department Head Signature: _____ Date: _____

For Workers Comp Dept. Use Only
Rate of Pay: week / month
Level 1 Org:
SSN:

Please send completed form to Jon Glick, Workers Compensation Manager, Controller's Office, Parsons Hall Room 109.
Any questions, call ext. 7951 or email Jon.Glick@indstate.edu.

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