

**THE UNIVERSITY OF ARIZONA
SUPERVISOR'S REPORT OF EMPLOYEE INJURY / ILLNESS
SEVEN (7) CALENDAR DAY DEADLINE TO FILE**

Department subject to assessment up to \$10,000 for late filing
All information is required to comply with both Workers' Compensation Law and OSHA.
Call 1-800-837-8583 to make an immediate report.

THIS FORM MUST STILL BE COMPLETED EVEN IF THE 800 NUMBER IS CALLED

INJURED/ILL EMPLOYEE INFORMATION	WORK INFORMATION
Name _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title _____
S.S. No. _____ DOB _____	Date of hire _____ Normal work shift _____
Home Phone _____	Department _____
Home Address _____	Campus Address _____
City _____ State _____ Zip _____	Dept. # _____ Work Phone _____
Marital Status (S M D W) _____ # of dependants _____	

INJURY OR ILLNESS INFORMATION

(See reverse side for Instructions)

Date of incident/illness _____ Time _____ Nature of injury/illness _____ Area of body effected: _____

Location _____ room#/shop# _____ Type of injury/illness _____

If off campus, give address _____

HOW DOES THE EMPLOYEE EXPLAIN INJURY OR ILLNESS _____

Did anyone see employee get injured? No Yes. Name of witness: _____

How was the injury treated? Check all that apply. First Aid Campus Health Emergency Room Employee's HMO No Treatment

State **where** for each box checked above: _____

SUPERVISOR'S INFORMATION

Name/Title of supervisor _____ Phone number _____

Date supervisor notified of injury/illness _____ Did injury result in time lost from work? Yes No

Did the task resulting in injury require personal protective equipment (PPE)? Yes No Was it being worn? Yes No

If PPE required and not worn, Explain _____

Do you have any reason to believe injury/illness may not have occurred on the job? Yes No State your concerns: _____

What Supervisory actions will be taken to prevent recurrence? _____

Did you or employee call the 1-800 #? (800-837-8583) No Yes If "Yes", indicate the date: _____

If the information provided indicates a significant potential for a more serious event, RM&S may conduct a more detailed incident investigation. (Instructions will be provided.)

Signature of Supervisor (required) _____ Date _____

NOTE: FORM MUST BE COMPLETELY FILLED OUT TO BE ACCEPTED!

FOR FASTER RESPONSE, FAX TO (520)-621-3706

CAMPUS MAIL: P. O. Box 210300;

HAND DELIVER: 220 W. Sixth St., 4th FL South (BLDG. 300A)

U.S. MAIL: Risk Management & Safety, Worker's Comp, P.O. BOX 210300, Tucson AZ 85721-0300

MAKE COPIES FOR SUPERVISOR AND EMPLOYEE

