



EMPLOYEE INJURY AND ILLNESS REPORT

Must be submitted within one working day of incident. Please see back of form for complete instructions.

1. Employee information

Last name First Banner ID# Date of birth Sex M F Address City, State, Zip County Home Phone

2. Employment information

Campus: Oxford MUM MUH Department Sub-department Job Title Time at present position <6 months 6 mo.-1 yr. 1-2 yrs. 2-5 yrs. 5+ yrs.

3. Witness information No Witness

Name Phone Address City, State, Zip

4. Incident details

Date Time AM PM Person reported to Date reported Body part(s) affected Did the incident occur on university property? Describe incident and injury

This section to be completed by treating physician.

5. Complete only if medical treatment was sought.

Did injury or illness lead to: Lost work days? No Yes TOTAL number of days away from work, starting the day after the injury or illness Date returned to work Did injury or illness lead to: Restriction of motion or work? No Yes TOTAL number of days of restricted motion or work Medical facility/treatment: Student Health McCullough-Hyde Other Treatment date Treatment time AM PM Treating physician Describe medical treatment received

6. Employee Signature

Date

I certify that the above information is accurate to the best of my knowledge. I authorize my medical provider(s) to release information to Miami University and its representatives. By virtue of my signature, I authorize the Miami University Student Health Service to release all information obtained in my treatment to its current managed care organization.

7. Supervisor

A. I fully agree with the details of the incident as described above. B. I do not fully agree with the details of the incident as described above. (explain on a separate sheet of paper and attach to this report) C. Please advise what corrective actions you have taken to avoid a reoccurrence of this injury or illness: D. Print name Signature Date Phone

EHSO USE ONLY Recordable injury Recordable illness Investigation indicated Non-recordable injury

Case Number Additional information requested



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MIAMI  
UNIVERSITY

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- B.  I *do not* fully agree with the details of the incident as described above. *(explain on a separate sheet of paper and attach to this report)*
- C. Please advise what corrective actions you have taken to avoid a reoccurrence of this injury or illness: \_\_\_\_\_  
\_\_\_\_\_
- D. Print name \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_ Phone \_\_\_\_\_

**EHSO USE ONLY**     Recordable injury     Recordable illness     Investigation indicated     Non-recordable injury

Case Number \_\_\_\_\_     Additional information requested

## WHAT TO DO IF YOU ARE INJURED:

- 1. In an emergency, *seek care immediately.***
- 2. Report injury to Supervisor immediately and file an Employee Injury and Illness Report within 1 working day of accident.**
- 3. Student Health Center will give an initial consultation and one follow-up for non-emergency care that is needed (you must have the Employee Injury and Illness Report *with you* for any injuries that are not obvious, i.e. pulled muscle, pain in back, etc.)**
- 4. If further treatment is necessary, file a first report of injury with Workers' Compensation by calling Compmanagement Health Systems at **888-247-7799. The Workers' Compensation policy number for Miami University 10003143-0.****
- 5. Employee to fill out sections 1 through 4 and section 6.**
- 6. Treating physician is to fill out section 5 - or employee if treating physician is not available.**