

INJURY REPORT FORM

Employees who are injured while working must notify their supervisor immediately and complete this form.
Supervisors must ensure completion of form, proper signatures, and delivery to the Insurance Office *within 48 hours of injury*.
Email • InsuranceOffice@brown.edu

Personal Information:

Name of injured employee _____ Sex: M ___ F ___ Date of birth _____
Home address (local for student workers) _____ Telephone # _____
City _____ State _____ Zip Code _____ Last 4 digits of SSN _____
Marital Status: Married ___ Divorced ___ Single ___
Check One: Admin Staff ___ Union Staff ___ Faculty ___ Graduate Student ___ Undergrad Student ___
If student: Did mishap occur as direct result of course of study ___ or employment ___? Please check one.
Job Title _____ Department _____ Date of hire _____
Supervisor's name _____ Campus phone number _____ Box number _____
Pay type: Weekly ___ Bi-Weekly ___ Monthly ___ Preferred language of employee: English ___ Spanish ___ Portuguese ___ Other ___

Medical Information:

Did the mishap occur as a direct result of employment at Brown University? Yes ___ No ___
Did you go to University Health Services? Yes ___ No ___
Did University Health Services *refer* you to an another medical provider? Yes ___ No ___ If yes, Name _____
Did you see *any* medical provider (i.e. emergency room, private physician)? Yes ___ No ___ If yes, Name _____
Did you (or will you) miss any days from work? Yes ___ No ___ If yes, List dates _____

Accident Information:

WHEN did the mishap occur? Date _____ Time _____ AM ___ PM ___
Time work day started? Time _____ AM ___ PM ___
Days normally worked each week: Sunday ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Saturday ___

WHERE did the mishap occur? (Please be specific)

WITNESSES? (Please indicate the name of anyone who was with you when you were injured or witnessed your injury)

HOW did the mishap occur? (Please be specific)

WHAT injuries were sustained, if any? (Example: cut-left hand, bruise-right knee)

Employee's Signature

Date

Unsigned or incomplete reports will be returned causing delay in processing

Supervisor Information: Corrective measures taken or planned.

Supervisor's Signature

Date

Unsigned or incomplete reports will be returned causing delay in processing

Review/Action:



REPORT OF POTENTIAL UNSAFE CONDITIONS

Accident Report on reverse side. Please use this side to report *potential* mishaps and unsafe practices. Make a copy for your records.

Email · InsuranceOffice@brown.edu

Potential Accidents:

Name of originator _____ Date _____

Campus box # _____ Campus telephone # _____

Has your supervisor been informed? Check one: Yes__ No__ If No, *will* you inform your supervisor ? Yes__ No__

NOTE: Confidentiality will be preserved if the originator desires.

Description:

The Problem (Please be specific as to times, locations, and circumstances)

Review/Action: