Case Western Reserve University Occupational Injury/Illness Report

This Report must be completed whenever an occupational injury/illness has occurred. This form should be printed, completed, signed by the employee, as well as the employee's supervisor. Once completed and signed, the Report should be faxed or emailed to both Dina Leinweber, Office of Risk Management & Insurance and to Felice Porter in the Department of Environmental Health & Safety (EHS) at the following:

Dina Leinweber at <u>dina.leinweber@case.edu</u> or fax # 368-8690. Felice Porter at <u>felice.porter@case.edu</u> or fax # 368-2236.

Name:		Employee ID #:		
Date of Birth:		Male	Female	
Home Address:				
Telephone #'s (work):				
Department:	Occupation:	Superv	Supervisor:	
Date of Injury/Illness: Dat	e of Hire:Time of Injury:	Time employee	e began work:	
Was the employee performing his/he Provide specific details of accident (i.			No:	
Witnesses (if applicable):				
Type of treatment received: First Aid University Health Serv	icesEmergency Room	Private Physician	Other	
Name of physician or health care pro	fessional:			
Name of facility where treatment wa	s received:			
Was employee hospitalized overnigh	t as an in-patient? Yes No			
Did employee miss days from work (i	f so, how many): W	/as employee paid for days	missed:	
Employee's Signature:		Date:		
Supervisor's Signature:		Date:		