**Report of Claimed Occupational Injury or Illness**

**Workers’ Compensation**

1407 S. Harrison, Suite 110

East Lansing, MI 48823

Phone: 517-353-4434

Fax: 517-432-4102

**Note: Please complete the entire form**

* Notify Public Safety of accidents requiring immediate investigation (517-355-2221).
* Send authorization (to invoice MSU) with employee, except in extreme emergency.
* Forward copies within 24 hours of accident for MIOSHA compliance.
* Please print or type this form. If completing online, use the tab key to move to each field.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Claimant: |       | Social Security Number: | ###-##-      |

(last name, first name and middle initial) (last 4 digits only)

|  |  |  |  |
| --- | --- | --- | --- |
| Local/Home Address: |        | Z-PID Number: |       |

(house number and street, city, state, zip code)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Birth: |       | Male |[ ]  Female |[ ]  Phone Number: |       | Student Number: |       |

(MM/DD/YYYY)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date/Time of Claimed Event: |       |[ ]  a.m. |[ ]  p.m. | Time Employee Began Work |       | Day of Week: |       |

 (MM/DD/YYYY, 9:15 a.m.)

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or materials the employee was using. Be specific:

Describe the events that caused the claimed injury/illness:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Union Affiliation: |       | Department Name: |       | Department code: |       |

 (please state if none) (8-digit number)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Job Title or Classification: |       | Years on Present Job: |       | University Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MSU Employment Date: |       | Supervisor: |       | Supervisor Phone Number: |       |

|  |
| --- |
| Where did claimed injury/illness occur? (check one) |
|[ ]  On-Campus – Near or in what building? |       |
|[ ]  Off-Campus – on MSU Property – Address: |       |
|[ ]  Off-Campus – on University Business – City: |       |

|  |
| --- |
| Describe Claimed Injury/Illness (Be specific, i.e. sprain, strain, body part, left/right):       |

|  |  |
| --- | --- |
| Witness Name and Department or Address: |       |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Was there Medical Treatment? | Yes |[ ]  No |[ ]  Blood Clean-Up Required? | Yes |[ ]  No |[ ]  Hospitalized? | Yes |[ ]  No |[ ]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Medical Treatment Date? |       |  Death? | Yes |[ ]  No |[ ]

(MM/DD/YYYY)

|  |  |
| --- | --- |
| Place of Treatment (Name): |       |

|  |
| --- |
|  To the best of my knowledge these statements are correct, and I have received a copy of this report: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Signature:** |       | **Date:** |       |

|  |  |
| --- | --- |
| Preventative Action to be Taken: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Department Account Number Employee is Paid From: |       | Number of Days Employee will be Assigned to Alternate Work Duties: |       |

**Department Signatures**

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisor**:** |       | Department Chair: |       |

 (Date) (Date)

**Note: If employee is unable to work on any day following date of injury/illness, due to claimed injury/illness, report lost time and return to work date on Injury Absence Report (InjuryAbsenceReport.pdf)**

DISTRIBUTION: Original to Workers’ Compensation; 1 copy to each of the following: Department and Employee.