**MILLERSVILLE UNIVERSITY**
**EMPLOYEE'S REPORT OF INJURY**

Name _______________________________________________ Perner # __________________________

Address ________________________________________________________________________
Street City State Zip

Home or Cell number ______________________ Occupation ____________________________________

Department ______________________________________________________________________

Birthdate _____________________Married ___ Yes ___ No Number of Dependents _______________

List Any Other Employment ______________________________________________________________

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

Date of Injury ____________________________ Time ________________________AM____ PM _____

Date Injury was Reported _________________________________________________________________

Who was Injury reported to ______________________________________________________________

Describe fully how injury happened: ________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Injury Witnessed by: ___________________________________________________________________

What part(s) of your body were injured ____________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Did you stop work as a result of your injury _________ When ____________________________________

From whom did you receive your first medical treatment ________________________________________

Date of first treatment __________________________________________________________________

Are you still undergoing treatment _________________________________________________________

Signature ____________________________________________ Date ______________________________