EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

Please complete entire form & return to Human Resources *within 48 hours* {fax 872-3700}.
If you have questions, please call 872-3017

1. Date of Report	2. Date of Injury and Time ☐ AM ☐ PM	3. Starting Time on Date of Injury ☐ AM ☐ PM	4. If Employee Back to Work, Give Date
5. If Fatal Injury, Give Date of Death	6. Date Employer Knew of Injury	7. Date Disability Began	
8. Employer Millersville University		9. Person Making Out This Report **(SUPERVISOR)**	
10. Employer's Street Address PO Box 1002		11. City, State, Zip Code Millersville, PA 17551-0302	
12. Employee Name (LAST, FIRST, MIDDLE INITIAL)		13. Employee Social Security Number (Not PERNER)	
14. Employee Address (Street, City, County, St, and Zip Code)		15. Employee Telephone Number (Include Area Code)	16. Male ☐ Female ☐

17. Date of Birth	18. Married ☐ Yes ☐ No	19. Number of Children under 18	20. ☐ Full-time ☐ Part-Time	21. Occupation/Job Title 22. Department

23. Place of Injury Employer's Premises: ☐ Yes ☐ No

Give exact location - office, room, area, building name _____

Give exact location – street, city, county, state _____

24. WHAT WAS EMPLOYEE DOING WHEN INJURED? (BE SPECIFIC, IF USING TOOLS OR EQUIPMENT OR HANDLING MATERIAL, NAME THEM AND TELL WHAT HE WAS DOING WITH THEM)

25. HOW DID INJURY OCCUR? (DESCRIBE FULLY THE EVENTS WHICH RESULTED IN INJURY OR DISEASE. TELL WHAT HAPPENED AND HOW IT HAPPENED. NAME ANY OBJECTS OR SUBSTANCES INVOLVED AND TELL HOW THEY WERE INVOLVED. GIVE FULL DETAILS ON ALL FACTORS WHICH LED OR CONTRIBUTED TO INJURY OR DISEASE)

26. Did Injury or Disease Occur Because of Mechanical Defect ☐ No ☐ Yes (If yes, please describe)	27. Did Injury or Disease Occur Because of Unsafe Act ☐ No ☐ Yes (If yes, please describe)
_____ _____	_____ _____

28. NATURE AND LOCATION OF INJURY OR DISEASE – DESCRIBE FULLY – INCLUDING PARTS OF BODY AFFECTED

29. ATTENDING PHYSICIAN AND ADDRESS (IF HOSPITAL INVOLVED – INDICATE)

SIGNATURE OF PERSON IN 9 ABOVE

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7/2005