EMPLOYER’S REPORT OF OCCUPATIONAL INJURY OR DISEASE

Please complete entire form & return to Human Resources within 48 hours (fax 871-7950). If you have questions, please call 871-4950

<table>
<thead>
<tr>
<th>1. Date of Report (today)</th>
<th>2. Date of Injury</th>
<th>3. Starting Time on Date of Injury AM</th>
<th>PM</th>
<th>4. If Employee Back to Work, Give Date</th>
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<tr>
<th>5. If Fatal Injury, Give Date of Death</th>
<th>6. Date Supervisor Knew of Injury</th>
<th>7. Date Disability Began</th>
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</thead>
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8. Employer: Millersville University

9. Person Making Out This Report (SUPERVISOR) PERNER#

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 Address (Street, City, County, St, and Zip Code):

14. Date of Birth:

15. Married: Yes No

16. Number of Children under 18

17. Full-time Part-Time

18. Occupation/Job Title:

19. Department:

20. Place of Injury Employer’s Premises: Yes No

21. Give exact location - office, room, area, building name

22. Give exact location – street, city, county, state

23. 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)

24. 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)

25. Did Injury or Disease Occur Because of Mechanical Defect Yes (If yes, please describe)

26. Did Injury or Disease Occur Because of Unsafe Act Yes (If yes, please describe)

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

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

SIGNATURE OF PERSON IN 9 ABOVE

2/2010