

WORKERS' COMPENSATION

EMPLOYEE INCIDENT REPORT: WORK RELATED INCIDENTS ONLY

(Please Fill Out Completely, Sign and Date. Attach Additional Sheets, As Needed.)

Today's Date: _____	Date of Injury: _____
Name: _____	Time of Injury: _____
SSN: _____	Birth Date: _____
Home Address: _____	Marital Status: _____
City, Zip: _____	Campus Phone: _____
Home/Cell Phone: _____	Campus Address: _____
University Employee I.D. No. _____ (PeopleSoft No.)	Campus E-mail: _____

Location of Where Injury Occurred: _____	Time Employee Began Work on Date of Injury: _____
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On University Premises When Injury Occurred? Yes _____ No _____	Doing Regular Duties When Injury Occurred? Yes _____ No _____
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Describe How Injury Occurred? _____

What Part of Body Was Injured (be specific, such as **right** hand, **left** knee)? _____

Witness and Her/His Phone Number (include all witnesses): _____

Name of Supervisor: _____	Campus Address: _____
Date Supervisor Notified of Injury: _____	Campus Phone: _____
	Campus E-mail: _____

Treating Physician (please check one **AND** indicate date of initial visit):

<input type="checkbox"/> UMD Health Services	If after hours, on weekends or holidays
<input type="checkbox"/> UMD Quick Care (for regular employees only)	<input type="checkbox"/> St. Mary's Hospital and Emergency Room
<input type="checkbox"/> Duluth Clinic Occupational Medicine	<input type="checkbox"/> St. Luke's Hospital and Emergency Room
<input type="checkbox"/> St. Luke's Occupational Health	
<input type="checkbox"/> Duluth Clinic URGENT Care	
<input type="checkbox"/> St. Luke's URGENT Care	Date of initial visit: _____
<input type="checkbox"/> St. Luke's Miller Creek Clinic / Urgent Care (NRRI employees only)	
<input type="checkbox"/> Grand Itasca Clinic and Hospital (Coleraine employees only)	
<input type="checkbox"/> Family Physician / Specialist	

Name of Treating Physician: _____ Address: _____

First Treatment Date: _____ Phone: _____

First Day Off Work: _____ Return to Work Date: _____

Date Your Department/Unit Notified of Lost Time: _____ Your University Department/Unit: _____

Employee's Job Title: _____

Employee's Signature: _____ **Today's Date:** _____

TO EMPLOYEE: FORWARD THIS COMPLETED REPORT TO YOUR SUPERVISOR AS SOON AS POSSIBLE.

Supervisor / Department Payroll Staff Must Complete the Following and Supervisor Must Sign and Date

Employee's Job Class Code: _____ Department Code: _____ Rate Per Hour: _____

Days Per Week: _____ Hours Worked Per Day: _____

Initial Date of Hire at the University of Minnesota: _____

Comments (Optional): *Attach additional sheet, as needed.*

Supervisor Signature: _____ **Today's Date:** _____

o Employees must report job-related injuries/illnesses as soon as practicable to the employee's supervisor.

Employee must report job-related injuries/illnesses as soon as practical to the employee's supervisor and complete this form. Forward completed form to UMD Workers' Compensation Coordinator, 255 Darland Administration Building (FAX: 218-726-8827). Contact UMD Workers' Compensation Coordinator at 726-6827, if you have any questions.

*****TO EMPLOYEE AND SUPERVISOR: PLEASE KEEP A COPY OF THIS REPORT FOR YOUR RECORD*****