

# FIRST REPORT OF INJURY

To Be Completed by the Supervisor  
Send copy to IPFW HR – Kettler Hall G56



REPORT ALL WORKER'S COMPENSATION INJURIES TO LIBERTY MUTUAL  
The 1-800 CLAIMS SERVICE CENTER is open 24 hours a day including  
Weekends and Holidays. For efficient service, have the following  
**Information available for the Customer Service Representative.**  
**CALL: 1-800-362-0000**

**Attention:** This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state worker's compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-595 and 29CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

## Information about the employee

- 1) Full name \_\_\_\_\_  
Social Security # \_\_\_\_\_
- 2) Street : \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: (XXX) - XXX - XXXX
- 3) Date of birth: \_\_\_\_\_
- 4) Date hired: \_\_\_\_\_
- 5) Gender  Male  Female

## Information about the physician or other health care professional

- 6) Name of physician or other health care professional \_\_\_\_\_
- 7) If treatment was given away from the worksite, where was it given?  
Facility name \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_
- 8) Was employee treated in an emergency room?  
 Yes  No
- 9) Was employee hospitalized overnight as an in-patient?  
 Yes  No

## Information about the case

- 10) Case number from the Log \_\_\_\_\_ (REM will assign)
- 11) Date of injury or illness \_\_\_\_/\_\_\_\_/\_\_\_\_
- 12) Time employee began work \_\_\_\_\_ AM/PM
- 13) Time of event \_\_\_\_\_ AM/PM  Check if time cannot be determined
- 14) **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
- 15) **What happened?** Tell us how the injury occurred. *Examples:* "when ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 16) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 17) **What object or substance directly harmed the employee?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
- 18) **If the employee died, when did death occur?** Date of death \_\_\_\_/\_\_\_\_/\_\_\_\_ (call REM immediately at 41425)

Completed by _____
Title _____
Phone (____) _____-_____
Date ____/____/____

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**ADDITIONAL EMPLOYEE INFORMATION**

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OCCUPATION: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_ DATE/TIME SUPERVISOR NOTIFIED: \_\_\_\_\_

PERSON NOTIFIED AT PURDUE: \_\_\_\_\_ DEPARTMENT NUMBER (LOCATION CODE): \_\_\_\_\_

EMPLOYMENT FT  Temp  PT  HOURS/WEEK: \_\_\_\_\_ MONTHLY WAGE: \_\_\_\_\_ HOURLY WAGE: \_\_\_\_\_ PAY PERIOD: Monthly   
STATUS: If Grad Student: Paid Project  Student Project  Bi-Weekly

PAID FOR DATE OF INJURY? YES  NO  MARITAL STATUS: S. M. W. D. \_\_\_\_\_ NO. OF DEPENDENTS: \_\_\_\_\_

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**ADDITIONAL ACCIDENT INFORMATION**

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LOST TIME? YES  NO  LAST DAY WORKED: \_\_\_\_\_

FIRST FULL DAY OUT: \_\_\_\_\_ (ESTIMATED) DATE RETURN TO WORK: \_\_\_\_\_

EXACT LOCATION OF ACCIDENT (e.g. *Civil--Loading dock north end*): \_\_\_\_\_

WERE OTHERS INJURED FROM THIS INCIDENT? YES  NO  IF YES, LIST NAMES AND PHONE #: \_\_\_\_\_  
WERE THERE ANY WITNESSES? YES  NO

WERE THERE UNSAFE ACT(S) OR FAILURE TO ACT BY EMPLOYEE(S)? IF YES DESCRIBE: \_\_\_\_\_  
YES  NO

WERE THERE MECHANICAL, PHYSICAL OR ENVIRONMENTAL CONDITIONS THAT CONTRIBUTED TO ACCIDENT? IF YES DESCRIBE: \_\_\_\_\_  
YES  NO

WAS PPE REQUIRED PER HAZARD ASSESSMENT FORM? YES  NO  IF YES LIST REQUIRED PPE: \_\_\_\_\_

WAS REQUIRED PPE WORN? YES  NO  WAS PROPER PPE AVAILABLE? YES  NO  DID PPE FAIL? YES  NO

WHAT IS THE ROOT CAUSE OF THE ACCIDENT? \_\_\_\_\_

CORRECTIVE ACTION REQUIRED: \_\_\_\_\_

PARTY RESPONSIBLE FOR CORRECTIVE ACTION: \_\_\_\_\_ DATE COMPLETED: \_\_\_\_\_

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**ADDITIONAL COMMENTS & INFORMATION**

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- \* Sick leave will be used to supplement other benefits.
- Employee wants vacation used to supplement after sick leave is exhausted.
  - Employee does not want sick leave or vacation used to supplement other benefits.

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**Claim number:** \_\_\_\_\_ **Completed by:** \_\_\_\_\_

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\* Disclosure of Employee's Social Security number is in accordance with IC22-3-4-13