THE UNIVERSITY OF CHICAGO | Human Resources

Effective 05/2015
Questions about this form? Contact HR-Leave Administration
Email: leaveadministration@uchicago.edu

Employee's Statement of Injury or Illness - Workers' Compensation

PLEASE PRINT

Today's Date:_____

Employee Name: _____ SSN: _____ Birth Date: _____

Employee Home Address: _____ City, ST, Zip: _____

Home Phone Number: _____ Emergency Contact & Number: _____

Department: _____ Position: _____ Supervisor: _____

Date of Accident, Injury-Illness: _____ Time: _____ Physical Location: _____

Did you report the accident, injury, illness? **YES NO** (Circle one) Date Reported: _____

How did you report it? **In person By Phone By e-mail** (Circle one, if other fill in blank) Other: _____

To whom did you report it? _____ Title _____

What were you doing when the accident, injury, illness occurred:

_____

_____

What tools or equipment were you using at the time?

_____

Describe the accident and injury/illness:

_____

_____

Select the area(s) where there is an injury; the type of injury; and, indicate right, left, front or back:

	Eye	Face Head	Shoulder	Chest Ribs	Arm	Wrist	Hand	Fingers	Back	Leg	Knee	Foot Toes
Burn												
Bruise												
Cut												
Gash												
Rash												
Scrape												
Scratch												
Sprain												
Fracture												

Signature: _____ Date: _____