

THIEL COLLEGE

REPORT OF OCCUPATIONAL INJURY OR DISEASE

Date of Report: ____/____/____	Date and Time of Injury: ____/____/____ ____:____ AM ____:____ PM	Normal Shift Hours: ____:____ AM to ____:____ PM	If time lost, will return to work: ____/____/____ NO Time Lost: ____
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Employee Name: _____ Gender: ____ Male ____ Female

(First) (MI) (Last) Telephone Number: ____ - ____

Employee's Mailing Address: _____ Mailing Address same as Home Address? (y/n) ____

Street: _____

City: _____ State: ____ Zip: _____

County of Residence: _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____

Hire Date: ____/____/____ FT ____ PT ____ Current Wage or Salary: \$ _____

Regular Assigned Department: _____ Occupation: _____

Department When Injured: _____ Occupation When Injured: _____

Place of Injury: _____ Employer's Premises? (y/n) ____

What was the employee doing when injured? (Be specific. If using tools or equipment, or handling materials name the item and activity being performed.)

How did the injury occur? (Describe fully the events which resulted in the 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 the injury or disease.)

Nature and location of the injury or disease: (Describe fully – Include parts of body affected, left or right side, upper or lower, etc.)

Any witnesses (y/n) ____ Name: _____ Telephone Number: ____ - ____
(First) (MI) (Last)

Name: _____ Telephone Number: ____ - ____
(First) (MI) (Last)

In-house First Aid (y/n) ____ By: _____

What type of First Aid was given?

Taken to Medical facility: ____ Ambulance ____ College Transport ____ Personal Vehicle

Medical facility name: _____

Check here if: ____ No Medical Assistance Sought (Incident Report Only)

Employee's Signature: _____ Date: ____/____/____

Supervisor's Signature: _____ Date: ____/____/____