# Occupational Injury / Illness Report Form

**Occupational Injury/Illness Report Form MUST be completed by the injured employee's Supervisor.**
**This form is required to be received by the Office of Risk Management within 24 hrs. of a reported injury.**

**Office of Risk Mgmt. | 25 Buick Street Rm. 130 Boston MA 02215 | P: 617-353-3020 | Email: Injury@bu.edu**

## Employee Information

| | | |
|---|---|---|
| Print Employee Name (Last, First, MI): | | Today's Date: |
| Home Address (Street) | | Birth Date: |
| Home Address (City, State, Zip) | | BU ID: |
| Email Address: | | Primary Phone Number: |
| Job Title: | | Date of Hire: |
| Department: | | |
| Supervisor's Name: | Supervisor's Phone Number: | Employment Status:<br>☐ Full-Time<br>☐ Part-Time |
| Student Status<br>☐ Full-Time ☐ N/A<br>☐ Part-Time | Shift Hours: | Gender:<br>☐ Male<br>☐ Female |

## Injury / Accident Information

| | |
|---|---|
| Date of Injury:<br><br>Time of Injury: | Employee's Last Date Worked: |
| Did injury result in Loss of Time from work?<br>☐ Yes<br>☐ No<br>☐ Unknown | Employee's Return to Work Date: |

### Nature of Injury

| | | |
|---|---|---|
| ☐ Abrasion | ☐ Absorption/Ingestion/Inhaled | ☐ Allergic Reaction |
| ☐ Amputation | ☐ Animal/Insect Bite | ☐ Asphyxiation |
| ☐ Body Fluids | ☐ Bruise | ☐ Burn |
| ☐ Concussion | ☐ Contagious Disease | ☐ Cut |
| ☐ Dislocation | ☐ Fall, Slip or Trip | ☐ Fracture |
| ☐ Laceration | ☐ Lifting/Pushing/Pulling | ☐ Other |
| ☐ Poisoning | ☐ Puncture | ☐ Repetitive Stress Injury |
| ☐ Scratch | ☐ Shock | ☐ Splinter |
| ☐ Sprain | ☐ Strain | ☐ Struggle/Resisting Arrest |

| Part of Body Injured | | |
|---|---|---|
| ☐ Abdomen | ☐ Face | ☐ Leg Right |
| ☐ Ankle Right | ☐ Foot Right | ☐ Mouth |
| ☐ Back | ☐ Forearm Right | ☐ Nose |
| ☐ Chest | ☐ Hand Right | ☐ Shoulder Right |
| ☐ Ear Right | ☐ Head | ☐ Teeth |
| ☐ Elbow Right | ☐ Knee Right | ☐ Wrist Right |
| ☐ Eye Right | ☐ Breast Right | ☐ Neck |
| ☐ Upper Extremity | ☐ Respiratory System | ☐ Lower Extremity |
| ☐ Multiple Body Parts | | |

| Initial Medical Treatment | |
|---|---|
| ☐ None Required | ☐ Refused Treatment |
| ☐ First Aid Only | ☐ Occ. Health Center |
| ☐ Research Occ. Health Center (RHOP) | ☐ Physician/Treatment Facility Visit |
| ☐ Emergency Room Care | ☐ Unknown |

## Accident/Incident Details

Address Location of Accident: _____

Reported to whom: _____ Date Reported: _____

Witness(s) Name: _____Contact Info: _____

Witness(s) Name: _____ Contact Info: _____

**Describe Cause of the Employee's Injury**:

_____

_____

_____

_____

_____

**Supervisor Comments:**

_____

_____

_____

_____

_____

**Supervisor Signature:** _____ **Date**_____

The supervisor is to advise Boston University Environmental Health and Safety (EH&S) of immediate hazards which warrant prompt investigation and/or remedy.

***Please click here to submit this completed and signed form via email.***