



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: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Student Status <input type="checkbox"/> Full-Time N/A <input type="checkbox"/> Part-Time	Shift Hours:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Injury / Accident Information

Date of Injury:	Employee's Last Date Worked:
Time of Injury:	Employee's Return to Work Date:
Did injury result in Loss of Time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Nature of Injury		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Absorption/Ingestion/Inhaled	<input type="checkbox"/> Allergic Reaction
<input type="checkbox"/> Amputation	<input type="checkbox"/> Animal/Insect Bite	<input type="checkbox"/> Asphyxiation
<input type="checkbox"/> Body Fluids	<input type="checkbox"/> Bruise	<input type="checkbox"/> Burn
<input type="checkbox"/> Concussion	<input type="checkbox"/> Contagious Disease	<input type="checkbox"/> Cut
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Fall, Slip or Trip	<input type="checkbox"/> Fracture
<input type="checkbox"/> Laceration	<input type="checkbox"/> Lifting/Pushing/Pulling	<input type="checkbox"/> Other
<input type="checkbox"/> Poisoning	<input type="checkbox"/> Puncture	<input type="checkbox"/> Repetitive Stress Injury
<input type="checkbox"/> Scratch	<input type="checkbox"/> Shock	<input type="checkbox"/> Splinter
<input type="checkbox"/> Sprain	<input type="checkbox"/> Strain	<input type="checkbox"/> Struggle/Resisting Arrest

Part of Body Injured		
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Face	<input type="checkbox"/> Leg
<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Mouth
<input type="checkbox"/> Back	<input type="checkbox"/> Forearm	<input type="checkbox"/> Nose
<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Ear	<input type="checkbox"/> Head	<input type="checkbox"/> Teeth
<input type="checkbox"/> Elbow	<input type="checkbox"/> Knee	<input type="checkbox"/> Wrist
<input type="checkbox"/> Eye	<input type="checkbox"/> Breast	<input type="checkbox"/> Neck
<input type="checkbox"/> Upper Extremity	<input type="checkbox"/> Respiratory System	<input type="checkbox"/> Lower Extremity
<input type="checkbox"/> Multiple Body Parts		

Initial Medical Treatment	
<input type="checkbox"/> None Required	<input type="checkbox"/> Refused Treatment
<input type="checkbox"/> First Aid Only	<input type="checkbox"/> Occ. Health Center
<input type="checkbox"/> Research Occ. Health Center (RHOP)	<input type="checkbox"/> Physician/Treatment Facility Visit
<input type="checkbox"/> Emergency Room Care	<input type="checkbox"/> Unknown

Accident/Incident Details

Address Location of Accident: _____

Reported to whom: _____ Date Reported: _____

Witness(s) Name: _____ Contact Info: _____

Witness(s) Name: _____ Contact Info: _____

<p>Describe Cause of the Employee's Injury:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>Supervisor Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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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.