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 Management | 25 Buick Street, Room 130, Boston, MA 02215 | Phone: 617-353-3020 | injury@bu.edu

EMPLOYEE INFORMATION

Last Name | **First Name** | **MI** | **Today's Date** | **Employee BU ID #** | **Date of Birth (mm/dd/yyyy)**

Home Street Address | **City** | **State** | **Zip Code**

Email | **Primary Phone Number** | **Gender** ◯ Male ◯ Female | **Marital Status** ◯ Single ◯ Married

Job Title | **Department**

Date of Hire (mm/dd/yyyy) | **Supervisor Name** | **Supervisor Phone Number**

Rate of Pay | **Shift Hours** | **Employment Status** ◯ Full-time ◯ Part-time

INJURY/ACCIDENT INFORMATION

Date of Injury (mm/dd/yyyy) | **Did injury result in loss of time from work?** ◯ Yes ◯ No ◯ Unknown | **Employee's Last Day Worked** | **Employee's Return to Work Date**

Time of Injury (hour:minute am/pm) | **Nature of Injury** SELECT ONE | **Injured Body Part** SELECT ONE

Initial Medical Treatment:

◯ None Required ◯ Emergency Room Care ◯ Physician/Treatment Facility Visit
◯ First Aid Only ◯ Refused Treatment ◯ Unknown
◯ Research Occ. Health Program ◯ Occupational Health Center

ACCIDENT/INCIDENT DETAILS

Location of Accident | **Reported to Whom** | **Date Reported**

Witness(s) Name | **Witness Contact Info**

Witness(s) Name | **Witness Contact Info**

Describe Cause of the Employee's Injury

Supervisor Comments

Supervisor Signature | **Date**

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