WORK RELATED INJURY/ILLNESS FORM

This form is to be completed for all job-related injuries or illnesses – regardless of the extent of injury.

TO BE COMPLETED BY SUPERVISOR

Complete this form and provide the 801 form to the employee within 24 hours of knowledge of incident
FAX completed forms to Human Resource Services at (541) 552-8508 or email to barlowm@sou.edu

Supervisor Name (Print)	Supervisor's Signature	Phone Number	Date

Name of Injured Worker	Employee ID#:	Department	Phone Number	Work Ext.

Employees Work Title		Scheduled Work Days	Shift Start Time	Shift End Time
	☐ APSOU ☐ Student Employee ☐ SEIU Local 503, OPEU ☐ Administrative/Unclassified	S M T W TH F S ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ AM Hour _____ ☐ PM	☐ AM Hour _____ ☐ PM

Date of Injury/Illness:	Time of Injury/Illness: ☐ AM Hour _____ ☐ PM	Date of Your Knowledge:	Date Claim form 801 given to Employee:

Did injury occur on Employer's Premises? YES ☐ NO ☐

Injured at (Bldg/Rm# or Location):

Was the appropriate safety equipment used?: YES ☐ NO ☐

Has employee received proper training?: YES ☐ NO ☐

Were there witnesses? YES ☐ NO ☐
If yes, please list Name/Department/Phone:
1._____ 3. _____
2._____ 4._____

Did injury result in lost time after the date of injury? YES ☐ NO ☐
Has employee returned to work? YES ☐ NO ☐
If employee died, date of death: _____

Last day worked: _____
Date returned to work: _____

Describe specific activity the employee was performing when event occurred (e.g., Welding seams of metal forms, loading boxes onto truck).

Describe how the injury/illness occurred (e.g. Employee stepped back to inspect work and slipped on scrap metal. As he fell, he brushed against fresh weld, and burned right hand). If additional space is needed use bottom of next page.

NATURE OF INJURY		BODY PART INJURED		ACTION
☐ Abrasion	☐ Fracture	☐ Head	☐ Wrist (L/R) _____	☐ First Aid Only
☐ Bruise	☐ Foreign Body	☐ Face	☐ Finger _____	☐ Required doctor's care
☐ Sprain/Strain	☐ Burn	☐ Eye	☐ Knee (L/R) _____	☐ Hospitalized *
☐ Laceration	☐ Syncope (fainting)	☐ Neck	☐ Leg (L/R) _____	☐ Time Loss
☐ Puncture	☐ Poison Oak	☐ Back	☐ Shoulder (L/R) _____	☐ No Injury/Incident only
☐ Dermatitis	☐ Other _____	☐ Arm (L/R) _____	☐ Foot (L/R) _____	
		☐ Ankle (L/R) _____	☐ Toe _____	* Was OSHA notified?
		☐ Groin	☐ Other_____	YES ☐ NO ☐

Were there any unsafe acts? YES ☐ NO ☐

- ☐ Operating without authority
- ☐ Operating at Unsafe speed
- ☐ Using equipment incorrectly
- ☐ Taking unsafe posture/position
- ☐ Failure to use personal protective equipment
- ☐ Lack of training
- ☐ Other _____

Reasons for Unsafe act: _____
_____

Were there any unsafe conditions? YES ☐ NO ☐

- ☐ Improperly guarded
- ☐ Defective tool or equipment
- ☐ Poor housekeeping
- ☐ Improper Lighting
- ☐ Improper ventilation (dust, fumes, etc.)
- ☐ Unsafe Design/Construction
- ☐ Slippery or other unsafe surface
- ☐ Hazardous weather or environment
- ☐ Contact with poisonous plants, chemicals etc.
- ☐ Hazardous work procedure:
- ☐ Hazardous dress or apparel
- ☐ Other: _____

Reasons for Unsafe Conditions: _____
_____

What practical corrective action will be taken by supervisor to prevent recurrence? _____
_____

If employee is admitted to the hospital, the Supervisor must contact the Environmental Safety Manager at (541) 552-6232, and/or the HR Leave Coordinator at (541) 552-8119. SOU is required to notify OSHA within 24 hours of an injury resulting in hospitalization.

Supervisor's Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE
(Sign only ONE box below)

EMPLOYEE ACKNOWEDGMENT IF SEEKING MEDICAL TREATMENT

☐ I will be seeking medical treatment for this injury/illness

I have been provided with form 801. YES ☐ NO ☐

If seeking medical treatment I understand that I must provide form 801 to the HR Leave Coordinator at (541) 552-8508 fax, email to barlowm@sou.edu, or deliver to Human Resource Services, Churchill Hall Room 159, 1250 Siskiyou Blvd., Ashland OR 97520 within 24 hours.

Signature of Employee: _____ Date: _____

EMPLOYEE ACKNOWLEDGMENT IF NOT SEEKING MEDICAL TREATMENT

☐ I am NOT seeking medical treatment for this injury/illness

If NO medical treatment is required, employee acknowledges this is an Incident Report only and verifies the following:

- I have not lost any time from work beyond the incident date;
- I have been offered medical treatment but decline to see a physician at this time;
- I have been informed that I have one (1) year from the date of this incident to seek medical treatment; and
- I will notify the HR Leave Coordinator immediately at (541) 552-8119, or barlowm@sou.edu if I wish to request medical treatment.

Signature of Employee: _____ Date: _____