Workers' Compensation Office
109 Rowe Hall
Phone: (989) 774-7177
Fax: (989) 774-1417
Email: workerscomp@cmich.edu

EMPLOYEE ACCIDENTAL WORK-RELATED PERSONAL INJURY REPORT

(This form should be completed and sent to the Workers' Compensation Office within 24 hours after the accident)

Name of Injured Employee: _____ Employee or Student ID#: _____ Birth Date: _____ ☐Male ☐Female

Employee Group: _____ Department: _____ Job Title: _____ Phone #: _____

Home Address: _____ Supervisor's Name: _____

Incident Date: _____ Time of Incident: _____ Time Shift Started: _____ Date Reported: _____

Describe what the employee was doing just before the incident occurred:

_____

_____

_____

Describe the events that caused the injury:

_____

_____

_____

Body Part Injured (i.e., left arm, third finger right hand, etc.): _____ Incident Location:_____

Name of person(s) who witnessed this incident: _____

Physician/Place of Initial Treatment: ☐ None ☐ Ready Care/COMP ☐ McLaren ER ☐ Other:_____

Treatment rendered: _____

Ongoing medical treatment for this injury? ☐ Yes ☐ No

Employee Work Status: ☐ Continued to work normal scheduled hours without restrictions
☐ Continued to work normal scheduled hours with restrictions
☐ Did not return to work

If the employee was given work restrictions, please describe: _____

_____

To the best of my knowledge these statements are correct, and I have received a copy of this report:

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Witness Signature (if applicable): _____ Date: _____