

**CEDARVILLE UNIVERSITY**  
**EMPLOYEE'S REPORT OF INCIDENT & INJURY**

Date Report Filed: \_\_\_\_\_

Please PRINT in INK

EMPLOYEE

Name: \_\_\_\_\_  MALE  FEMALE  
Home Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City-State-Zip \_\_\_\_\_ S.S.N. \_\_\_\_\_  
Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Date of injury or onset of symptoms \_\_\_\_\_ 200\_\_ Time \_\_\_\_\_  AM  PM  
Please describe what caused the injury or symptoms. What were you doing just before the incident, and what did you do after the incident? Please be specific and name any objects or substances involved. (If you need more space, please use the back of this form). PLEASE INCLUDE THE LOCATION WHERE THE INCIDENT/INJURY OCCURRED!

Did you report this injury/incident to anyone?  YES  NO If "NO", why not? \_\_\_\_\_

If "YES", to whom did you report it? Title/position \_\_\_\_\_ When? \_\_\_\_\_

Did anyone else see what happened?  YES  NO If yes, who? \_\_\_\_\_

What part(s) of your body was/were affected? (Please be specific: i.e. right elbow, left knee, right index finger)

What type of injury did you experience? (Please be specific: i.e. bruise, scrape, cut, strain, pull).

Was any first aid provided on the scene?  YES  NO If "YES", describe: \_\_\_\_\_

Did you seek any other medical treatment?  YES  NO When? \_\_\_\_\_

Where? \_\_\_\_\_ If "NO", explain why: \_\_\_\_\_

Is this an aggravation of a previous injury/symptom?  YES  NO

If "YES" when were you last treated for the previous injury?

By whom were you treated?

Have you ever had a similar injury?  YES  NO If "YES" please describe:

MEDICAL RELEASE

***Under current workers' compensation law, the employer is entitled to a signed medical release.***

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the illness/injury described above, to disclose such information to my employer, CompManagement Health Systems, Inc. and employer designated representative. A copy of this form will serve as the original.

Employee Name: (please print) \_\_\_\_\_ Date: (required) \_\_\_\_\_

Employee Signature: \_\_\_\_\_