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 _____

INCIDENT or INJURY

Date of injury **or** onset of symptoms _____ 202_ _____ 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: _____

Update: Mar 2021