

Roger Williams University and Roger Williams University School of Law
Incident/Injury/Illness Report

Please complete this form in its entirety. Please print clearly.
The form MUST be returned to Human Resources within 24 hours of incident/injury/illness.

Section 1 Employee Information	SSN _____ - _____ - _____
Last Name _____	First Name _____
Home Address _____	
City _____	State _____ Zip Code _____
Phone (_____) _____ - _____	Date of Hire ____/____/____
Gender _____ M _____ F	Date of Birth ____/____/____
Occupation _____	Department _____

Section 2 Incident/Injury/Illness Information
Date of Injury ____/____/____ Time of Injury/Incident ____:____ AM/PM
Time Workday Began ____:____ AM/PM
First Full Day Lost From Work ____/____/____ Date Returned to Work ____/____/____

Where did the injury/incident/illness occur?

Specifically, what were you doing when you were injured?

List injured body parts and nature of injury (ex: broken left finger, lower back strain) Be Specific.

Witness Information (Name, Phone and Address)

Employee Signature _____ Date ____/____/____

Section 3 Supervisor/Manager Information
Was there a Specific Incident/Injury/Illness? _____ YES _____ NO _____ UNKNOWN
Did you witness the Incident/Injury/Illness? _____ YES _____ NO

Provide detailed information regarding what you witnessed or understand to have happened.

Was employee sent for medical treatment? ____ YES ____ NO ____ UNKNOWN ____ REFUSED
If YES, what facility? Name: _____
Address _____
City _____ State _____ Zip _____
Phone (_____) _____ - _____

Supervisor/Manager Name _____ Phone(_____) _____ - _____
Supervisor/Manager Signature _____ Date ____/____/____