



Employee Accident or Illness Report

Revised: 11/11

Office of Human Resources • 1845 Fairmount • Wichita, Kansas 67260-0015 • 316-978-3068

Notice: This report must be sent to Human Resources, Campus Box 15, by the employee or the supervisor within three days of the incident.

Injured Person: [] Employee [] Student Employee

Name _____ Age ____ Sex: [] Male [] Female
First Middle Last

Address _____ City _____ State _____ Zip _____

myWSU ID# _____ Home Telephone (include area code) _____

WSU office or department _____ Box _____ Ext. _____

Date of injury or occupational illness _____ Date _____ Hour _____ [] AM [] PM

Date disability began (if other than above) _____

What safety equipment was being used at the time of the injury?

[Empty text box for safety equipment]

Location of accident or exposure. (If the accident or exposure occurred on WSU premises, indicate the campus location. If the accident or exposure occurred outside the WSU premises at an identifiable address, list that address. If the accident or exposure occurred on a public highway or at any other location that cannot be identified by a number and street, please provide references locating the place of accident or exposure as accurately as possible.)

[Empty text box for location of accident]

How did the accident or exposure occur? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident or exposure. Use a separate sheet for additional space, if necessary.)

[Empty text box for description of accident]

What was the employee doing when he or she was injured? (Be specific. If the employee was using tools or equipment or handling material, name them and tell what the employee was doing with them.)

[Empty text box for employee activity]

Name the object or substance which directly injured the employee. (For example, identify the machine or thing that the employee struck against or which struck the employee; the poison inhaled or swallowed; the chemical or radiation which irritated the skin; or, in the case of strains, hernias, and so forth, the object the employee was lifting, pulling, and so on.)

[Empty text box for object/substance]

Describe the injury or illness in detail and indicate the part of the body affected. (For example, the amputation of the right index finger at the second joint, fracture of the ribs, or dermatitis of the left hand.)

[Empty text box for injury description]

Name of witness(es) (if applicable) _____ Telephone _____

Was the employee given first aid? Yes No

Who administered the first aid? WSU Student Health Services Other (Please specify.) _____

Was medical treatment required? Yes No

Who provided the medical treatment? (Please check all that apply.)

Via Christi Clinic Occupational Medicine

Via Christi Clinic Immediate Care

Wesley Medical Center Emergency Room

If employee was admitted, please provide the date _____

Other hospital emergency room (name & address) _____

If employee was admitted, please provide the date _____

Other physician (name & address) _____

Note: If you seek treatment from a medical provider other than WSU's approved providers, reimbursement may be limited to \$500 towards medical expenses.

Did the employee die? Yes No If "Yes," please provide the date _____

Has the employee returned to work? Yes No If "Yes," please provide the date _____

Is the employee on Regular duty Light duty

The dates of the employee's lost work days run from _____ through _____.

(Do not include the date of the accident. The date the employee returned to work may have to be telephoned later to Human Resources @ ext. 3068.)

Date of report _____ Prepared by _____
Employee or Supervisor

Name of employee's immediate supervisor _____ Extension _____

Distribution: Please forward to Human Resources, Campus Box 15, within three days of the incident.