EMPLOYEE INJURY REPORT FORM

UNIVERSITY OF SAN FRANCISCO
CHANGE THE WORLD FROM HERE

EMPLOYEE INFORMATION

Name: (First, Last, MI)

Date of Birth: CWID#:

Mailing Address:

Cell and/or Home Ph: Email:

EMPLOYEE JOB INFO

Regular Occupation:

Date of Hire: Employee Status: ☐ Full Time ☐ Part Time ☐ Other

Supervisor Name:

Supervisor Phone: Supervisor Email:

ACCIDENT INFORMATION

Date of Injury: Date Reported to Employer:

Did you loose any time at work? ☐ YES ☐ NO Date Last Worked:

Have you Returned to Work? ☐ YES ☐ NO

Briefly Describe Accident:

Nature of Injury (eg Fracture, Laceration, Sprain)

Part of Body Injured (eg Head, Arm, Leg)

Witness to Accident: Contact Info:

EMPLOYEE SIGNATURE: DATE:

University of San Francisco

RETURN FORM ASAP TO: Jill Bouchard x4801

jkbouchard@usfca.edu - FAX: 415-386-1074 - Lone Mt Main Room 339