EMPLOYEE'S WORK

University Of Wisconsin System
UW-

INJURY AND ILLNESS REPORT

FOR AGENCY USE ONLY
Claim Number
Claim Examiner / Representative

INSTRUCTIONS:
1. **Complete by the end of the workshift or within 24 hours of the injury.**
2. **Direct any questions to your agency Worker's Compensation Coordinator.**

Employee Name:	Preferred name:	Empl ID:	Date of Incident:	Time of Incident:	AM/PM
Work email:	Home/Cell Phone:	Supervisor Name:		Date Reported to Supervisor:	

Was Medical Treatment Required? ☐ Yes ☐ No First aid only ☐ Yes ☐ No Time Lost From Work ☐ Yes ☐ No	Last day worked (MM/DD/YY)	Name and Address of Treating Practitioner/Facility	

Exact location where the incident took place (inside, outside, building name, room, vehicle, etc.)

Describe in detail what you were doing and how the incident occurred. What injury or illness did you sustain, if any?

Witnesses (name, phone number, department)

Part of body injured (Check ***ALL*** that apply, and circle or indicate appropriate position) (Thumb = Finger 1, Great toe = Toe 1)

	Abdomen		Back U M L		Finger R L 1 2 3 4 5		Head		Mouth		Shoulder R L
	Ankle R L		Eye R L		Foot R L		Knee R L		Neck		Toe R L 1 2 3 4 5
	Arm R L		Elbow R L		Hand R L		Leg R L		Nose		Wrist R L
	Other (Please specify)						For Hand and Arm injuries circle your dominant arm : Right ☐ Left ☐				

Have you ever been treated for a similar injury or condition? ☐ Yes ☐ No	If Yes Date(s) of Treatment	Name and address of treating practitioner/facility of prior treatment

Please read carefully. I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination from employment. Further I understand that the signature below authorizes medical, mental health and chiropractic providers to release all medical, mental health and chiropractic records to the University Of Wisconsin System, Office of Risk Management at 780 Regent St., Madison, WI 53715

✍ **Signature**_____**Date** _____