OZARKS TECHNICAL COMMUNITY COLLEGE

Employee Report of Injury or Illness

(To be used for Worker's Compensation)

Please return completed form to Human Resources.

Part 1: Employee Information

Name _____ Sex _____ Race _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ SSN _____ OTC I.D. # _____

Home Phone _____ Cell Phone _____ Email _____

Department _____ Job Title _____ Employee ☐ P/T ☐ F/T

Supervisor _____ Shift/Start Time _____ Date of Hire _____

Part 2: Incident Information

Date of Incident _____ Time of Incident _____ Date Reported _____

Incident Location _____ Employer Premises ☐ Yes ☐ No

Specific description of incident and how it occurred (include as much detail as possible) _____

_____

_____

Treatment given or other action taken _____

_____

Safeguards or safety equipment provided to prevent injury _____

Physician/Location providing treatment _____

Declining Medical Coverage/Worker's Compensation Benefits Yes No

Signature confirming declining of coverage: _____ *Date:* _____

Part 3: Witness to Incident

Name(s) _____

Address(es) _____

Phone(s) _____

Person filing report _____ *Date* _____

Office Use

Hire Date _____ Workers Comp Representative _____

Gross Pay/Week _____ Date Workers Comp Contacted _____ Reference # _____