

**THE UNIVERSITY OF ARIZONA
SUPERVISOR'S REPORT OF EMPLOYEE INJURY / ILLNESS
SEVEN (7) CALENDAR DAY DEADLINE TO FILE**

Department subject to assessment up to \$10,000 for late filing
All information is required to comply with both Workers' Compensation law and OSHA
Call 1-800-837-8583 to make an immediate report

THIS FORM MUST STILL BE COMPLETED EVEN IF THE 800 NUMBER IS CALLED

INJURED/ILL EMPLOYEE INFORMATION

Name _____ Sex _____
S.S. No. _____ DOB _____
**The Arizona Industrial Commission requires use of your social security number under authority granted by Arizona Revised Statutes (ARS) section 23-908.*
Home Phone _____
Home Address _____
City _____ State _____ Zip _____
Marital Status (S M D W) _____ # of dependants _____

WORK INFORMATION

Job Title _____
Date of hire _____ Normal work shift _____
Department _____
Campus Address _____
Dept. # _____ Work Phone _____

INJURY OR ILLNESS INFORMATION

(See Next Page for Instructions)

Date of incident/illness _____ Time _____ Nature of injury/illness _____ Area of body effected: _____
Location _____ Rm.#;Shop# _____ Type of injury illness _____

If off campus give address _____

HOW DOES THE EMPLOYEE EXPLAIN INJURY OR ILLNESS

Did anyone see employee get injured? Yes No If so, who? _____

How was the injury treated? Check all that apply. First Aid Campus Health Emergency Room Employees HMO No Treatment

Where? (state for each box checked above): _____

SUPERVISOR'S INFORMATION

Name/Title of supervisor _____ Phone number _____
Date supervisor notified of injury/illness _____ Did injury result in time lost from work? Yes No
Did the task resulting in injury require personal protective equipment (PPE)? Yes No Was it being worn? Yes No
If PPE required and not worn; Explain _____
Do you have any reason to believe injury/illness may not have occurred on the job? Yes No State your concerns: _____
What Supervisory actions will be taken to prevent recurrence? _____
Did you or employee call the 1-800 number? Yes No If Yes, indicate the date: _____

If the information provided indicates a significant potential for a more serious event, RM&S may conduct a more detailed incident investigation (instructions will be provided)

Signature of Supervisor (required) _____ Date _____

FOR FASTER RESPONSE FAX TO (520)-621-3706

CAMPUS MAIL: P.O. BOX 210460 · HAND DELIVER: 1610 N. VINE (BLDG. #460) · U.S. MAIL: P.O. BOX 210460, TUCSON, AZ 85721-0460
MAKE COPIES FOR SUPERVISOR AND EMPLOYEE

EMPLOYEE RIGHT: Workers' compensation is a right of all U of A employees/student employees

SUPERVISOR'S MUST FILL OUT THIS REPORT FOR:

- 1) All incidents involving injury or job related illness.
- 2) All incidents that could have resulted in injury or illness.

PURPOSE OF REPORT:

- 1) To help prevent similar incidents in the future.
- 2) Support Workers' Compensation claim for injured/ill employee as applicable.
- 3) OSHA compliance

REPORT MUST BE FILED:

- 1) Any incident/illness should be reported initially to **1-800-837-8583**.
- 2) If the injury or illness required immediate medical treatment, you must report incident/illness to State Risk Management **1-800-837-8583** within 24 hours. Fax Report to University of Arizona, Risk Management & Safety, 621-3706, mail original to University of Arizona Risk Management & Safety, P.O. Box 210460, campus mail, or hand deliver to 1610 N. Vine (bldg. 460)
- 3) All other incidents must be filed in **SEVEN CALENDAR DAYS**.
- 4) By a supervisor or in their absence acting supervisor.
- 5) If additional space is needed please attach separate paperwork.

DESCRIPTION BY TYPE

NATURE OF INJURY CATEGORIES

Bodily Reaction		Amputation	Burn or Scald (heat)
Caught In, Under or Between		Burn (chemical)	Cancer
Contact w/Electric Current	Contact w/Temperature	Concussion	Contagious/Infectious
Contact w/Cold-Atmosphere	Contact w/Heat-Atmosphere	Contusion	Crushing/Bruise
Contact w/Cold Objects	Contact w/Substance	Cut/Laceration	Dermatitis/Rash
Contact w/Chemicals	Contact w/Radiations	Dislocation	Electric Shock
Contact w/Machinery	Contact w/Tools	Fracture	Freezing
Contact w/Radiations –Inhalation		Heart Attack	Heat Stroke
Contact w/Radiations –Ingestion		Hearing Loss	Hernia, Rupture
Contact w/Radiations –Absorption		Inflammation	Poisoning
Fall from Elevation	Fall from Materials	Pneumoconiosis	Puncture/Bite
Fall onto Objects	Fall on Same Level	Radiation	Scratches/Abrasions
Fall from Scaffold	Fall on Stairs	Sprains/Strains	Sunburn/Sunstroke
Fall to Walkway	Fall in Opening	Multiple Injuries	Occupational Disease
Fall from Vehicle			
Lifting Objects – Pulling/Pushing, welding or throwing			
Motor Vehicle Accidents – U of A Vehicle or personal Vehicle			
Public Transportation Accidents – Aircraft Accident			
Bus or Boat Accident - Streetcar or Subway Accident			
	- Taxi or Train Accident		
Rubbed or Abraded	- By Leaning, Kneeling, or Sitting		
	- By Vibrating Objects		
	- By Foreign Matter in Eye		
	- By Repetition of Pressure		

NOTICE: FORMS NOT COMPLETELY FILLED OUT WILL NOT BE ACCEPTED!

