University of Nebraska Lincoln

WORKERS' COMPENSATION INCIDENT REPORT

Print Employee's Name _____ Today's Date _____

Personnel # _____ Phone where you can be reached _____

Employer _____ Supervisor _____

INCIDENT INFORMATION

Date of Injury _____ Time _____ ☐am ☐pm Date Reported _____

To Whom Reported? _____ Did you miss time from work for the injury? ☐Yes ☐No

If yes, give dates and times _____

Returned to Work? ☐Yes/☐No ☐Full Duty/☐Light Duty **If no**, date expect to return? _____

What part of your body was injured? (*Right leg, left arm*) _____

What is the injury? (*Cut, Sprain, Bruise*) _____

Explain in detail how the injury occurred? _____

_____

_____

Where did the injury occur? (*Physical location*) _____

Any Witnesses? ☐Yes ☐No **If yes**, give names _____

Did you seek medical treatment? ☐Yes ☐No **If yes**, give date & time

Doctor's name _____ Return visit date _____

What type of treatment are you getting? _____

How are you getting along now? _____

Have you ever injured this part of your body before? ☐Yes ☐No
If yes, explain when, how and to what extent: _____

_____

What would you do to prevent this from happening again? _____

_____

Signature of Employee _____ Date _____