THE UNIVERSITY OF CHICAGO | Human Resources


Questions about this form? Contact HR Benefits
E-mail: benefits@uchicago.edu

# Supervisor's First Report – Workers' Compensation Claim of Injury/Illness

**PLEASE PRINT**

Department: _____ Date Notified of Injury/Illness: _____

Employee Name _____ Job Title: _____ Union: _____

Date Hired to Present Position: _____ Last Day Worked: _____

Date of Injury/Illness/Accident: _____ Time: _____ am/pm M-F Accident: Y / N

Specific Location of Accident: (address, building name, area in building or grounds):

_____

How did the accident/injury/illness occur: _____

_____

_____

What was the employee doing specifically at the time: _____

_____

Were the activities within the scope, responsibilities, duties and course of employment: Y / N

List any equipment or tools being used at the time: _____

_____

Identify contributing factors, if any at the time: _____

_____

List all injuries, where on the employee's body or nature of illness: _____

_____

_____

List witnesses and co-workers present, include contact information:

_____ _____

_____ _____

First person notified of injury/illness/accident: _____

UC Safety/Environmental Office notified: Y / N By: _____ Date: _____

Employee sent for medical attention: Y / N ER or UCOM Clinic: _____

Form completed by: _____ Title: _____

Signature: _____ Date: _____