Questions about this form? Contact HR-Leave Administration
E-mail: leaveadministration@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 of Injury/Illness/Accident: _____ Last Day Worked: _____ Time: _____ am/pm

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

_____

How did the accident/injury/illness occur; e.g., what was the employee doing? _____

_____

_____

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: _____

_____

Did the employee miss one or more full work day(s) as a result of this incident? If yes, provide specific dates and date of return to work. Did the individual return to work with limitations? _____

_____

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

_____ _____

_____ _____

First person notified of injury/illness/accident: _____

UOC 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: _____