MICHIGAN STATE UNIVERSITY

Workers' Compensation
1407 S. Harrison, Ste. 140
East Lansing, MI 48823
353-4434

REPORT OF CLAIMED OCCUPATIONAL INJURY OR ILLNESS

NOTE: COMPLETE ENTIRE FORM

- Notify **Public Safety** of accidents requiring **IMMEDIATE** investigation (355-2221)
- **SEND AUTHORIZATION** (TO INVOICE MSU) **WITH EMPLOYEE, EXCEPT IN EXTREME EMERGENCY**
- Forward copies within 24 hours of accident for **MIOSHA** compliance
- Please **print** or **type** this form. If completing on the web, use the **tab key** to move to each field.

Name of Claimant: _____ *(Last, First and MI)*

Soc. Sec. Number #: _____ *(9-digits only)*

Z-PID #: _____

Local/Home Address: _____ *(Number and Street, City, State and Zip)*

Telephone: _____

Date of Birth: _____ *(MM/DD/YY)* Male ☐ Female ☐

Student #: _____

Date & time of claimed event: _____ ☐ a.m. ☐ p.m. *(MM/DD/YY, 9:15 a.m.)*

Time employee began work: _____

Day of Week: _____

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or materials the employee was using. Be specific:

Describe the events that caused the claimed injury/illness:

Union Affiliation: *(If none, so state)* _____

Department Name: _____

Department Code (MAU, 5-digit #): _____

Job Title or Classification: _____

Years on Present Job: _____

University Address: _____

MSU Employment Date: _____

Supervisor: _____

Telephone: _____

Where did claimed injury/illness occur? (*Check one)*

☐ On-campus Near or in what building? _____

☐ Off-campus/on MSU Property: Address: _____

☐ Off-campus/on University Business: City _____ County _____ State _____

Describe claimed injury/illness (BE SPECIFIC, i.e. sprain, strain, body part):

Witness name and department or address: _____

Was there Medical Treatment? ☐ Yes ☐ No

Blood clean-up required? ☐ Yes ☐ No

First Medical Treatment (Date): _____ *(MM/DD/YY)*

Place of Treatment (Name): _____

Hospitalized: ☐ Yes ☐ No

Death: ☐ Yes ☐ No

To the best of my knowledge these statements are correct and I have received a copy of this report.

Employee Signature _____ Date: _____

Preventative action to be taken: _____

Department account number employee is paid from: _____

Number of days employee will be assigned to alternate work duties: _____

DEPARTMENT SIGNATURES: _____

Supervisor: _____ Date

Department Chair: _____ Date

Note: If employee is unable to work on any day following date of injury/illness, due to claimed injury/illness report lost time and return to work date on injury absence report (#140-2513)

DISTRIBUTION: Original to Workers' Compensation; 1 copy to each of the following: Department and Employee

(Stock # 140-2592) (Revised 06/06)