LOYOLA UNIVERSITY CHICAGO

Claim Number

# Report of Workplace Injury/Illness

**Instructions**: Injured Individual must complete this report, and send the information to your Supervisor for review. If the injured individual is unable to complete the form, then your Supervisor must do so.

**Name:**

**DOB:**

**Length of Service:**

**Title:**

**Sex:**

**Department:**

**Last 4 Digits of SSN:**

**Shift Start Time:**

**Campus**:

**Campus Ext.**:

**Date of incident:**

**Time of incident:**

**Location of incident:**

**Body Part Injured: (Select All Applicable)**:

| Left: | Right: | |
|---|---|---|
| ☐ | ☐ | Head |
| ☐ | ☐ | Eye |
| ☐ | ☐ | Neck |
| ☐ | ☐ | Back |
| ☐ | ☐ | Abdomen |
| ☐ | ☐ | Shoulder |
| ☐ | ☐ | Arm/Elbow |
| ☐ | ☐ | Hand/Wrist |
| ☐ | ☐ | Finger(s) |
| ☐ | ☐ | Leg |
| ☐ | ☐ | Knee |
| ☐ | ☐ | Foot/Ankle |
| ☐ | ☐ | Toe(s) |

**Description of injury/illness:**

**Previous injury/illness to the same body part?**

**If yes, please select the date of the previous injury/illness:**

**Description of activity surrounding the injury/illness:**

**Body fluid exposure:**

**Hazardous material exposure:**

**If a non - work related injury/illness, please explain:**

## Type of Occurrence

- ☐ No apparent injury/illness
- ☐ Strain/sprain
- ☐ Contusion
- ☐ Laceration
- ☐ Fracture
- ☐ Infection
- ☐ Burn
- ☐ Allergic Reaction
- ☐ Cumulative Trauma
- ☐ Occupational Disease
- ☐ Other (please explain):
- ☐ Animal Bite
- ☐ Needle Stick

## Possible Cause (Select All Applicable):

- ☐ Unaware of hazard
- ☐ Unclear as to policy/procedure
- ☐ Inadequate protective equipment/clothing
- ☐ Improper body mechanics
- ☐ Other (please specify):
- ☐ Premises defect
- ☐ Policy not followed
- ☐ Poor lighting
- ☐ Material on floor (please specify):
- ☐ Inadequate training
- ☐ Equipment malfunction/handling

## Planned Action for Future Prevention:

## Initial Disposition:

- ☐ No treatment necessary
- ☐ Refused Treatment
- ☐ First Aid in Department
- ☐ Employee Health
- ☐ Immediate Care Center
- ☐ Personal Physician
- ☐ Hospital ER

**Lost Time Expected:**

**Estimated Number of Days:**

Name of **Supervisor** during occurrence & Extension:

Name of **Witness** during occurrence & Extension:

Was the above report completed by the injured individual?
If not, by whom?

Report reviewed by Supervisor?

**When completed, please SUBMIT this form or print and fax to the LSC HR Office: (773) 508-2134**

SUBMIT