

**UCIC
EMPLOYEE INJURY REPORT
FAX: 800-706-9344 / PHONE: 800-641-6330**

*Date of Injury (day xx/xx/xx)	*Time of Injury	*Work Schedule on Date of Injury
*Employer	*Employee Name	First MI Last
*Employee Social Security Number	*Employee Date of Birth	
*Home Address	*City, State, Zip Code	
County	Home Phone	
Work Phone	Fax and/or E-mail Address (optional)	
*Job Title	Employee: <input type="checkbox"/> *Male <input type="checkbox"/> Single <input type="checkbox"/> *Female <input type="checkbox"/> Married	*State in which Employee was Hired
*Department	Number of Dependents:	
Status (Part-time, full-time, student, IC, Seasonal)	Hourly/Salary Wage, if known	*Date Hired
Supervisor	Normal Work Schedule	
Work Location/Department (as defined by UCIC)		

*What was Employee doing when incident occurred?	
*What Happened?	
*What was the Injury or Illness?	
*What Object or Substance if any, directly harmed the employee?	
Witness Name and Phone Number:	
*Fatal Injury? <input type="checkbox"/> Yes (If Fatal) _____ <input type="checkbox"/> No	*List Date of Death _____ Date of Disability (First day missed work)
Return to Work Date	Full Pay for Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was Safety Equipment Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Safety Equipment Used? <input type="checkbox"/> Yes <input type="checkbox"/> No

