

Office of Human Resources

Glenville State College
200 High St., Glenville, WV 26351
Phone (304) 462-4101
E-mail hr@glenville.edu

Workplace Injury/Illness Report Form

Use this form to report a workplace injury or illness. Please complete the form and submit it to the Office of Human Resources at the address above within 24 hours of the injury and illness. Please type or print clearly.

Injured Employee's Name		
Social Security Number		
Date of Birth		
Job Title		
Department/College/etc.		
Employee Date of Original Hire		
Date Employee Began Job Title Above		
Employee's Home Address		
Employee's Home Phone Number		
Employee's Status	<input type="checkbox"/> Regular – Status	<input type="checkbox"/> Temporary
	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time
Date of injury/illness. Please enter clearly the date. Example: May 23, 2002		
Time of injury/illness. Please enter clearly the time. Example: 10:00 a.m.		
Time employee began work on the day of injury/illness, entered in same form as time above.		
Did injury/illness occur on College property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical location where the injury/illness occurred (bldg, intersection, etc.)		
Did employee lose any time from work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did employee receive medical attention	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe type of treatment received		
Name of physician or hospital providing medical attention		
Did injury/illness involve time away from work beyond the date of injury/onset of illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe the exact body part(s) affected and the type of injury/illness sustained to each.		

Has employee sustained previous injury/incurred previous illness affecting same body parts?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe how the injury occurred/illness contracted.			
Enter names and telephone numbers of any witnesses to injury/illness.			
Name		Phone	
Name		Phone	
Name		Phone	
Supervisor's Name			
Supervisor's Phone			
Supervisor's E-mail			
Does supervisor have any reason to question this injury?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes to above question, do not enter comments. Supervisor will be contacted if information is needed.			
Supervisor's Signature		Date	
Employee's Signature		Date	
DISTRIBUTION: Original – Office of Human Resources, Copy – Employee, Copy, Supervisor			
HR SERVICES USE ONLY – ENTER WC/UC LOCATION CODE:			