THE UNIVERSITY OF ALABAMA

Departmental Report of ON-THE-JOB

Injury or Accident

INSTRUCTIONS: This report is to be submitted by the Dean or Department Head of any Faculty or Staff employee who becomes ill or is injured as a result of their employment with The University of Alabama. The injured employee carries this form to the medical facility at the time of treatment. After the treating physician signs this form, the original is sent to Risk Management, a copy is given to the employee to give to the supervisor, and a copy is retained by the medical facility. **The original should be sent to Risk Management, Box 870119, no later than two (2) work days following the injury.** Please follow these instructions in pursuing treatment for the injury. If you are unable to complete this form on-line, please print clearly.

Name: ____ SSN: ________________ DOB: _________________

Job Title: _______________________ Years in the Job: ____ Years at UA: ____ Work Phone: _______________

Shift: _______ Supervisor's Name: ____________________________ Account #: _______________________

Department: ____________________________ Job Site of Injury: ____________________________________

Date of Incident: ____________ Time of Incident: _______________ Date/Time Reported: ________________

Describe clearly how the incident occurred (attach additional sheets as necessary):

____

____

Witnesses: ____

Nature of Injury: ____

___ First Aid Only ___ University Medical Center ___ DCH – Tuscaloosa (if UMC closed)

___ Other (if out of town) Please Specify: _______________________________

Did any unsafe act or unsafe condition contribute to the accident/injury/illness? Yes ____ No ____

If yes, please describe (attach other sheets, if necessary):

____

Action taken to prevent similar incidents: ____

____

This information has been verified by investigation? Yes ____ No ____ Who: ______________________________

I certify that the injury described was incurred in the performance of my official duties. Physicians attending me are authorized to release to The Office of Risk Management the clinical data concerning my injury.

Supervisor's Signature: ___________________________ Title: __________________________________

Signature of injured/ill person: _______________________________

THE UNIVERSITY OF ALABAMA

Departmental Report of ON-THE-JOB

Injury or Accident

Medical Evaluation

Place of Treatment: _______________________ Date of Treatment: ______________ Time of Treatment: _______

Diagnosis or comments of physician regarding the injured/ill person:

Treatment:

Status of injured/ill person:

Return to work on: ________________ Return for follow-up care on: ______________

Referred to: ___________________________ Date: _______________

Signature of Attending Physician: _______________________________