Note: Must be completed and delivered to Human Resources by the business day following the Industrial Injury/Illness

University of the Pacific

Work Related Injury/Illness Report

To be filled out by the employee: (immediately after injury or as soon as possible if emergency

Name _____ I.D. # _____

Address _____ Zip Code _____ Phone # _____

Job Title _____ Birth Date _____ Salary _____

Location of work related injury/illness _____

Date of work related injury/illness _____ Hour of day _____ a.m./p.m.
month/day/year

Describe injury illness _____

_____

Describe what you were doing at time of injury/illness and cause _____

_____

Sign _____ Date _____
month/day/year

To be filled out by the SUPERVISOR OR ADMINISTRATOR (and delivered to Human Resources by the next business day even if employee portion not completed) (Use reverse side if needed)

Date injury reported _____ Hour of day _____ a.m./p.m.

To whom reported _____
Supervisor or Administrator

Kaiser Occupational Medical Service authorized? ☐ Yes ☐ No

If yes, date _____ Hour _____ a.m./p.m.

Describe injury/illness _____

_____

How did it happen _____

_____

Did employee remain at work? ☐ Yes ☐ No

Did employee return to work after the treatment? ☐ Yes ☐ No

Suggestion to prevent recurrence _____

_____

Signature _____ Title _____ Date _____