**UCIC**

**EMPLOYEE INJURY REPORT**

**Fax: 800-706-9344 / Phone: 800-641-6330**

<table>
<thead>
<tr>
<th>*Date of Injury (day mm/dd/yy)</th>
<th>*Time of Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Work Schedule on Date of Injury</td>
<td></td>
</tr>
<tr>
<td>*Employee Name</td>
<td>First</td>
</tr>
<tr>
<td>*Employee Date of Birth</td>
<td></td>
</tr>
<tr>
<td>*City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td></td>
</tr>
<tr>
<td>Fax and/or E-mail Address (optional)</td>
<td></td>
</tr>
<tr>
<td>Employee:</td>
<td>*Male</td>
</tr>
<tr>
<td>*Female</td>
<td>Married</td>
</tr>
<tr>
<td>Number of Dependents:</td>
<td></td>
</tr>
<tr>
<td>Status (Part-time, full-time, student, IC, Seasonal)</td>
<td></td>
</tr>
<tr>
<td>Hourly/Salary Wage, if known</td>
<td>*Date Hired</td>
</tr>
<tr>
<td>Normal Work Schedule</td>
<td></td>
</tr>
</tbody>
</table>

**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?**  
☐ Yes  (If Fatal)  
☐ No  

*List Date of Death  
Date of Disability (First day missed work)

**Return to Work Date**  
Full Pay for Date of Injury?  
☐ Yes  ☐ No  
Was Safety Equipment Provided?  
☐ Yes  ☐ No  
Was Safety Equipment Used?  
☐ Yes  ☐ No
**NATURE OF INJURY**

- Abrasion
- Amputation
- Bruise
- Burn Chemical
- Burn Thermal
- Carpal Tunnel
- Contusion
- Cut / Laceration
- Dermatitis
- Dislocation
- Electrical Shock
- Eye Injury
- Fracture
- Hernia
- Infection
- Infection
- Irritation Joint or Muscle
- Other:
- Puncture Wound
- Sprain / Strain

**BODY PART**

- Abdomen
- Ankle
- Arm
- Back
- Chest
- Elbow
- Finger
- Foot
- Forearm
- Groin
- Hand
- Other:

  - L  
  - R

- Head / Face
- Hip
- Knee
- Leg
- Multiple:
- Neck
- Shoulder
- Thigh
- Thumb
- Toe(s)

**TREATMENT**

- No Medical Treatment
- Minor by Employee
- Clinic / Hospital
- Panel Physician
- Employee Physician
- Emergency Care*
- Hospitalized more than 24 hours*

**NAME OF PHYSICIAN/MEDICAL CENTER, ETC.**

- *Name of Physician/Facility or other medical professional providing care
- *Address
- *City
- *State
- *Zip Code
- *Phone/Fax Number

**REPORT OF INJURY**

- Date and Time Employer Notified
- To Whom
- *Name and title of Person Completing Report
- *Phone Number/Fax Number
- *Date Report Completed

- Injured Employee Signature
- Date

*Equivalent information asked on OSHA forms (complete where applicable)*