URI INCIDENT/INJURY REPORT FORM

PLEASE PRINT IN BLACK INK. BE SURE TO PROVIDE ALL REQUESTED INFORMATION.

1. EMPLOYEE REPORT:

__ MAIN CAMPUS __ PROVIDENCE CAMPUS __ BAY CAMPUS __ ALTON JONES __ OTHER

LAST NAME: MIDDLE INITIAL: FIRST NAME:

ADDRESS: Street,#: City: State: Zip:

HOME PHONE: SOC SEC#: - - SEX: M F AGE:

JOB TITLE: DATE OF INCIDENT:

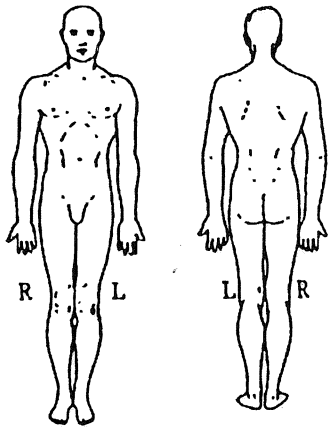
DEPARTMENT NORMALLY ASSIGNED: TIME OF INCIDENT:_____AM/PM

BUILDING, FLOOR AND/OR AREA WHERE INCIDENT OCCURRED:

HOW LONG (HRS.) HAD YOU BEEN WORKING WHEN THIS OCCURRED?:_____

DO YOU HAVE SUPPLEMENTAL EMPLOYMENT? YES___ NO___

INDICATE ON THESE FIGURES THE AFFECTED BODY PARTS



DESCRIBE AND ILLUSTRATE (AT LEFT) YOUR INJURY:_____

DESCRIBE THE INCIDENT:

EMPLOYEE SIGNATURE: DATE:

WITNESS NAME: (PRINT)

WITNESS SIGNATURE: DATE:

II. MANAGER'S REPORT:

WAS THE EMPLOYEE OUT OF WORK DUE TO THIS INJURY? Y___ N ___

WAS THERE A SPECIFIC INCIDENT/ACCIDENT? Y__ N__ UNKNOWN __ DID YOU WITNESS THE INCIDENT/ACCIDENT? Y__ N__

GIVE A STEP BY STEP DESCRIPTION OF WHAT YOU UNDERSTAND TO HAVE HAPPENED.

WAS EMPLOYEE SENT TO DESIGNATED HEALTH CARE FACILITY FOR EVALUATION? Y__ N__

1. __ BODILY MOTION	3. __ OBJECT HANDLING	4. __ CONTACT	5. __ SLIP/FALL	6. __ EXPOSURE/INHALATION
8. __ CAUGHT 9. __ COLLISION/UPSET	10. __ CUT BY	11. __ ASSAULT	12. __ MOTOR VEHICLE	
13. __ MISCELLANEOUS				

MANAGER'S NAME (PRINT): SIGNATURE: DATE:

DEPARTMENT COST CENTER: TITLE:

WHITE: DIV. WC PINK: Department
YELLOW: Personnel GOLD: Medical Facility

USP-14A