MICHIGAN STATE UNIVERSITY | Human Resources

Report of Claimed Occupational Injury or Illness

Workers' Compensation
1407 S. Harrison, Suite 110
East Lansing, MI 48823
Phone: 517-353-4434
Fax: 517-432-4102

Note: Please complete the entire form

- ✓ Notify Public Safety of accidents requiring immediate investigation (517-355-2221).
- ✓ Send authorization (to invoice MSU) with employee, except in extreme emergency.
- ✓ Forward copies within 24 hours of accident for MIOSHA compliance.
- ✓ Please print or type this form. If completing online, use the tab key to move to each field.

Name of Claimant: _____ Social Security Number: ###-##-____
(last name, first name and middle initial) (last 4 digits only)

Local/Home Address: _____ Z-PID Number: _____
(house number and street, city, state, zip code)

Date of Birth: _____ Male Female Phone Number: _____ Student Number: _____
(MM/DD/YYYY)

Date/Time of Claimed Event: _____ a.m. p.m. Time Employee Began Work _____ Day of Week: _____
(MM/DD/YYYY, 9:15 a.m.)

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or materials the employee was using. Be specific:

Describe the events that caused the claimed injury/illness:

Union Affiliation: _____ Department Name: _____ Department code: _____
(please state if none) (8-digit number)

Job Title or Classification: _____ Years on Present Job: _____ University Address: _____

MSU Employment Date: _____ Supervisor: _____ Supervisor Phone Number: _____

Where did claimed injury/illness occur? (check one)
On-Campus – Near or in what building? _____
Off-Campus – on MSU Property – Address: _____
Off-Campus – on University Business – City: _____

Describe Claimed Injury/Illness (Be specific, i.e. sprain, strain, body part, left/right):

Witness Name and Department or Address:

Was there Medical Treatment? Yes No Blood Clean-Up Required? Yes No Hospitalized? Yes No

First Medical Treatment Date? _____ Death? Yes No
(MM/DD/YYYY)

Place of Treatment (Name):

➡ To the best of my knowledge these statements are correct, and I have received a copy of this report:

Employee Signature: _____ Date:

Preventative Action to be Taken:

Department Account Number Employee is Paid From: _____

Number of Days Employee will be Assigned to Alternate Work Duties:

Department Signatures

Supervisor: _____ Department Chair:
(Date) (Date)

Note: If employee is unable to work on any day following date of injury/illness, due to claimed injury/illness, report lost time and return to work date on Injury Absence Report (InjuryAbsenceReport.pdf)

DISTRIBUTION: Original to Workers' Compensation; 1 copy to each of the following: Department and Employee.