Ozarks Technical Community College

Internal Report of Injury

(To be used for Worker’s Compensation or Student Incident)

*Please return completed form to the Office of Administrative Services*

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| Part 1: Claimant Information |

Name  Student  Employee  P/T  F/T

 Last First Middle Initial

Address Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_  Male  Female

 Street

 Name of Spouse

 City State Zip

OTC I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_ Number of Dependents

Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor

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| Part 2: Accident Information |

Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Injury \_\_\_\_\_\_\_\_\_\_\_ Time Employee Began Work

Exact location where injury occurred

Specific description of injury and how it occurred (include as much detail as possible) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment given or other action taken

Safeguards or safety equipment provided to prevent injury

Physician providing treatment

 Name Address

Hospital or clinic where treatment was given

 Name Address

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| **Part 3: Witnesses to Incident** |

Name Name

Address Address

Phone Phone

Person filing report Date

4/2009

## Office Use

Hire Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Workers Comp Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gross Pay/Week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Workers Comp Contacted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reference # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_