

OZARKS TECHNICAL COMMUNITY COLLEGE

Employee Report of Injury or Illness

(To be used for Worker's Compensation)

Please return completed form to Human Resources.

Part 1: Employee Information

Name _____ Sex _____ Race _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ SSN _____ OTC I.D. # _____

Home Phone _____ Cell Phone _____ Email _____

Department _____ Job Title _____ Employee P/T F/T

Supervisor _____ Shift/Start Time _____ Date of Hire _____

Part 2: Incident Information

Date of Incident _____ Time of Incident _____ Date Reported _____

Incident Location _____ Employer Premises Yes No

Specific description of incident 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/Location providing treatment _____

Declining Medical Coverage/Worker's Compensation Benefits Yes No

Signature confirming declining of coverage: _____ Date: _____

Part 3: Witness to Incident

Name(s) _____

Address(es) _____

Phone(s) _____

Person filing report _____ Date _____

Office Use
Hire Date _____ Workers Comp Representative _____
Gross Pay/Week _____ Date Workers Comp Contacted _____ Reference # _____