

First Report of Injury, Illness Exposure, or Near-Miss

Employee Information

Generally, the Employee First Report of Injury, Illness Exposure or Near-Miss form should be filled out by the Injured Employee if they are able. In the rare event that the Injured Employee is unable to complete the form, a third party may fill out the form on behalf of the Injured Employee.

Please select the best option below that describes you as the individual filling out this form:

- The Injured Employee
- Supervisor of the Injured Employee
- Co-worker of the Injured Employee
- Witness

Employee Name First Name Middle Last Name

Employee T-Number

Phone Number Area Code Phone Number

Employee Email

Employee Address Street Address

City State / Province

Postal / Zip Code

This is a work-related Injury Illness Near-miss

Is this related to the Utah Shakespeare Festival? Yes No

What was the initial treatment? No medical treatment Minor by employer Minor by clinic/hospital Emergency Care Hospitalized longer than 24 hours

Work Information

Employee's Rate of Pay

Pay Units

Number of days employee works per week

Full pay for day of injury, illness, or near-miss? Yes No

Did salary continue? Yes No

SUU Department employee works for

Supervisor's Name First Name Last Name

Supervisor's E-mail

Date Supervisor Notified of Injury, Illness, or Near-Miss Month Day Year

Occurrence Information - Page 1

Date of Injury, Illness, or Near-Miss Occurrence Month Day Year

Time of Occurrence Hour Minute s

Time Employee Began Work Hour Minute s

Did the injury, illness exposure, or near-miss occur on employer's premises? Yes No

Describe the exact location of where the injury, illness exposure, or near-miss occurred.

Describe all of the equipment, materials, or chemicals the employee was using when injury, illness exposure, or near-miss occurred.

Describe step-by-step the work process that led up to the injury, illness exposure, or near-miss.

How did the injury or illness occur? Describe the sequence of events and include objects or substances that injured the employee or made the employee ill.

Did the injury, illness exposure, or near-miss happen during performance of regular duties? Yes No

Were safeguards or safety equipment provided? Yes No

If yes, were the safeguards and safety equipment used? Yes No

Was the injury, illness exposure, or near-miss caused by failure of a machine or product? Yes No

If this injury, illness exposure, or near-miss was caused by any person or company besides the employee, a co-employee, or the employer, please identify:

Name and Phone Number of Witness

What could have been done to prevent this injury, illness exposure, or near-miss?

Occurrence Information - Page 2

Type of Injury or Illness

Side of Body Affected Right Left Bi-lateral Unknown

Part of Body Affected

Has the employee injured this part of body before? Yes No

Provide details regarding previous injury.

Employee's Last Work Date Month Day Year

Date Employee Returned to Work Month Day Year

Date Employee's Disability began (if applicable) Month Day Year

If fatal, give the date of death. Month Day Year

Upon submitting this form, the response will be reviewed by appropriate parties. The employee's supervisor will also receive additional instructions to assist with assessing the situation.