WORKERS' COMPENSATION INJURY REPORT FORM

Please type or print legibly. Complete and submit this form to Human Resources within 24 hours of accident.
Faculty/Staff member must discuss the injury with supervisor.

Fax to: (616) 331-3216 or E-mail to: hro@gvsu.edu

For list of designated injury care centers, please visit www.gvsu.edu/hro/workers-compensation-28.htm or contact Human Resources at 331-2215.

Faculty or Staff Member Information

First Name:	Last Name:	G# or SSN:	
Phone Number:	Date of Birth:	Date of Hire:	Gender:
Street Address:	City:	State:	Zip:
Occupation:	Department:	Supervisor's Name:	

Injury Information

Time Staff Began Work: ☐AM ☐PM	Time of Injury: ☐ AM ☐PM ☐Undetermined	Date of Injury:	Date Reported:
# of Days Missed From Work (0, 1, etc.):	Last Day Worked (if applicable):	Date Returned:	Was staff member hospitalized overnight? ☐ Yes ☐ No

Describe equipment used and activity done prior to injury:

Describe how the injury happened:

What directly harmed staff member (floor, chemical, etc.)?	Where did the injury occur (building, etc.)?
Affected Body Part (include right, left):	Type of Injury (strain, cut, etc.):

Staff Member's Signature:	Date:

Was there medical treatment? ☐ Yes ☐ No	If treated, where? ☐ Campus Health or ☐Spectrum Health Occupational or ☐ Other* (e.g. ER, urgent care center) *Contact HR at 331-2215 to provide physician's information

Staff Member must provide HR and supervisor with medical discharge paperwork (work release, restrictions, etc.)

Supervisor's Report

Explain what caused the accident:

Describe the actions taken to prevent a recurrence of such incident:

Explain the corrective action to be taken:

Supervisor's Signature:	Date:	Office Phone Number:

Upon receipt of report from the employee, his/her supervisor is responsible for making sure that the report is completed in a timely manner and turned into the Human Resources Office
1090 JHZ, 1 Campus Drive, Allendale, MI 49401

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