

IMPORTANT: This report must be filed with the appropriate campus office within two (2) days of date of injury/illness

UNIVERSITY SYSTEM OF NEW HAMPSHIRE

CLL
 KSC
 PSC
 System
 UNH
 UNH-M

Report of Injury/Occupational Illness

IMPORTANT INFORMATION TO BE COMPLETED BY EMPLOYEE, STUDENT OR VISITOR

Name: _____ Soc. Sec. No: _____

Home Address: _____ Home Telephone: _____

Date of Birth: _____ Department: _____ Dept. Telephone _____

Date of Hire: _____ Hours worked/Day: _____ Days worked/Week: _____

Date of Injury/Illness: _____ Time: _____ Day of Week: _____

Hourly Rate: \$ _____ or Annual Rate: \$ _____ Occupation _____

Place Injury/Illness Occurred: _____

Describe fully how injury/illness occurred and indicate what person was doing when injury/illness occurred:

Nature and specific location of injury: _____

Probable length of disability: _____

Did you seek medical treatment? Yes No If Yes, Where: _____

Witness(es) _____

(List witness(es) name(s) and address(es) and attach witness(es) statements to this form)

Signature of person reporting injury/occupational illness: _____ Date: _____

IMPORTANT INFORMATION TO BE COMPLETED BY SUPERVISOR OR APPROPRIATE CAMPUS OFFICIAL:

Lost Time: Yes No If Yes, beginning date: _____ Has injured returned to work? Yes No If Yes, date returned: _____

NOTE: If no lost time as of the date of this report, please send written documentation of lost time when it occurs.

Describe results of accident investigation: _____

Date injury/illness reported to supervisor or campus official: _____

Name of supervisor or campus official (Print) _____

Signature supervisor or campus official _____ Date: _____

White - (UNH & UNH-M) - Facilities Service, Figment Hall
(CLL, KSC, PSC & System) - Human Resource/Personnel Office

Canary - Department