X A V I E R   U N I V E R S I T Y
INJURY/ILLNESS REPORT

I. **To Be Completed By Employee:**

NAME____

ADDRESS____

____

DATE AND TIME OF INJURY____

WHAT PART OF BODY WAS INJURED? BE SPECIFIC.__________________________

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DESCRIBE EXACTLY HOW INJURY OCCURRED_________________________________

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____

WAS THERE ANY WITNESS TO INJURY? IF SO, LIST NAMES___________________

____

TO WHOM WAS INJURY REPORTED? ____

(Supervisor's Name)

EMPLOYEE SIGNATURE____

II. **To Be Completed By Supervisor To Whom Injury Was Reported:**

DATE AND TIME INJURY WAS REPORTED TO SUPERVISOR______________________

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SUPERVISOR'S STATEMENT OF INJURY REPORT______________________________

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SUPERVISOR'S SIGNATURE____

*** Please Return To Human Resources Within 24 Hours (ML 5400 or Fax 3644).**