LOYOLA
UNIVERSITY CHICAGO

Claim Number

Report of Workplace Injury

Instructions: Injured Individual must complete this report, and send the information to your Supervisor for review. If the injured individual is unable to complete the form, then your Supervisor must do so.

Name:

Title:

Department:

Campus:

Campus Ext.:

Home Address:

City/State/Zip Code:

Sex:

DOB:

Last 4 Digits of SSN:

Shift Start Time:

Date of incident:

Time of incident:

Location of incident:

Body Part Injured: (Select All Applicable):

Left: Right

Head
Eye
Neck
Back

Left: Right:

Abdomen
Shoulder
Arm/Elbow
Hand/Wrist
Finger(s)

Left: Right:

Leg
Knee
Foot/Ankle
Toe(s)

Description of injury:

Previous injury to the same body part?

If yes, please select the date of the previous injury:

Description of activity surrounding the injury:

Body fluid exposure:

Hazardous material exposure:

If a non - work related injury, please explain:

Type of Occurrence

No apparent injury
Strain/sprain
Contusion
Laceration

Fracture
Infection
Burn
Allergic Reaction

Cumulative Trauma
Occupational Disease
Other (please explain):

Animal Bite
Needle Stick

Possible Cause (Select All Applicable):

Unaware of hazard
Unclear as to policy/procedure
Inadequate protective equipment/clothing
Improper body mechanics
Other (please specify):

Premises defect
Policy not followed
Poor lighting
Material on floor (please specify):

Inadequate training
Equipment malfunction/handling

Planned Action for Future Prevention:

Initial Disposition:

No treatment necessary
Refused Treatment

First Aid in Department
Employee Health

Immediate Care Center
Personal Physician
Hospital ER

Lost Time Expected:

Estimated Number of Days:

Name of **Supervisor** during occurrence & Extension:

Name of **Witness** during occurrence & Extension:

Was the above report completed by the injured individual?
If not, by whom?

Report reviewed by Supervisor?

When completed, please SUBMIT this form or print and fax to the LSC HR Office: (773) 508-2134