Report of On-the-Job Injury or Illness
Workers' Compensation Claim Form

Please type or print in ink to complete this form and send electronically to emprelations@bsu.edu or by campus mail to AD 335, Attn: WC Admin. Any questions about this form or the information requested should be directed to Employee Relations at 765-285-1823.

Injured Worker Information

Name (last, first, middle)		Job Title	Date Hired	
Date of Birth	◯ Male ◯ Female	Department	Wage	
Home Address Phone (_____) _____-_____	Supv. Name Phone (_____) _____-_____	Work Status ◯ Full-time ◯ Part-time ◯ Student Worker ◯ Grad. Stdt Worker	Hrs. worked per day	Days worked per week

This form completed by: ☐ Injured Worker ☐ Supervisor ☐ Other (Name, title, phone)
(please provide e-mail address)

Incident Information

Type: ◯ Injury ◯ Illness	Date of incident or knowledge of illness:	Time of Occurrence: _____ ☐ Time cannot be determined	Reported to Supv on:

What was the employee doing just prior to the incident? (Describe the activity and any tools, equipment and material being used.)

What happened? (Tell us how the incident occurred. Example: "when ladder slipped on wet floor, worker fell")

What was the injury or illness? (Tell the part of the body affected and how it was affected. Example: "bruised and cut right knee")

What object or substance directly harmed the employee? (Example: "concrete floor")

Witness(es) [Name(s), Phone or email(s)]:

Treatment Information (Check one)

◯ No medical treatment needed/self care
◯ BSU Health Center
◯ Emergency Room*
◯ Admitted to hospital overnight*
◯ Other*

◯ *Opportunity to seek medical treatment refused.*

_____
(Employee signature & date)

* Name of physician, health care provider, hospital or other offsite treatment facility

FOR EMP REL USE ONLY

Received:
BSU claim#
Submitted to State:
State claim #

Eligible for FML Yes No