UNIVERSITY & COLLEGE INSURANCE CONSORTIUM

SELF-INSURED SERVICES COMPANY, INC. SISCO

UCIC
EMPLOYEE INJURY REPORT
FAX: 410-583-5455 / PHONE: 888-377-7263 EXT: 2803

*Date of Injury (day xx/xx/xx)

*Time of Injury

*Work Schedule on Date of Injury

*Employer

*Employee Name First MI Last

*Employee Social Security Number

*Employee Date of Birth

*Home Address

*City, State, Zip Code

County

Home Phone

Work Phone

Fax and/or E-mail Address (optional)

*Job Title

Employee:
☐ *Male ☐ Single
☐ *Female ☐ Married

*State in which Employee was Hired

*Department

Number of Dependents:

Status (Part-time, full-time, student, IC, Seasonal)

Hourly/Salary Wage, if known

*Date Hired

Supervisor

Normal Work Schedule

Work Location/Department (as defined by UCIC)

*What was Employee doing when incident occurred?

*What Happened?

*What was the Injury or Illness?

*What Object or Substance if any, directly harmed the employee?

Witness Name and Phone NUmber:

*Fatal Injury? ☐ Yes ☐ No (If Fatal)

*List Date of Death

Date of Disability (First day missed work)

Return to Work Date

Full Pay for Date of Injury? ☐ Yes ☐ No

Was Safety Equipment Provided? ☐ Yes ☐ No

Was Safety Equipment Used? ☐ Yes ☐ No

University & College Insurance Consortium

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*NATURE OF INJURY

- ☐ Abrasion
- ☐ Amputation
- ☐ Bruise
- ☐ Burn Chemical
- ☐ Burn Thermal
- ☐ Carpal Tunnel
- ☐ Contusion
- ☐ Cut / Laceration
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Electrical Shock
- ☐ Eye Injury
- ☐ Fracture
- ☐ Hernia
- ☐ Infection
- ☐ Infection
- ☐ Irritation Joint or Muscle
- ☐ Other:
- ☐ Puncture Wound
- ☐ Sprain / Strain

*BODY PART

Body Part			
☐ Abdomen			
☐ Ankle	L ☐	R ☐	
☐ Arm	L ☐	R ☐	
☐ Back	Upper ☐	Middle ☐	Lower ☐
☐ Chest			
☐ Elbow	L ☐	R ☐	
☐ Finger	L ☐	R ☐	
☐ Foot	L ☐	R ☐	
☐ Forearm	L ☐	R ☐	
☐ Groin			
☐ Hand	L ☐	R ☐	
☐ Other:			
☐ Head / Face			
☐ Hip	L ☐	R ☐	
☐ Knee	L ☐	R ☐	
☐ Leg	L ☐	R ☐	
☐ Multiple:			
☐ Neck	L ☐	R ☐	
☐ Shoulder	L ☐	R ☐	
☐ Thigh	L ☐	R ☐	
☐ Thumb	L ☐	R ☐	
☐ Toe(s)	L ☐	R ☐	

TREATMENT

- ☐ No Medical Treatment
- ☐ Minor by Employee
- ☐ Clinic / Hospital
- ☐ Panel Physician
- ☐ Employee Physician
- ☐ Emergency Care*
- ☐ Hospitalized more than 24 hours*

NAME OF PHYSICIAN/MEDICAL CENTER, ETC.

*Name of Physician/Facility or other medical professional providing care

*Address

*City *State *Zip Code *Phone/Fax Number

REPORT OF INJURY

Date and Time Employer Notified | To Whom

*Name and title of Person Completing Report | *Phone Number/Fax Number | *Date Report Completed

Injured Employee Signature | Date

Equivalent information asked on OSHA forms *(complete where applicable)