University of Missouri

Report of Injury

This form should be completed for all employees injured on the job. The Supervisor should complete the report within 24 hrs of employee's Injury. Please press submit button at bottom, fax (573.882.7861) or email to **umrimwcclaims@umsystem.edu**

EMPLOYEE INFORMATION

Date of Incident	Employee Number	Campus
		☐ Columbia ☐ Kansas City ☐ Rolla ☐ St. Louis ☐ UM System ☐ Hospital

Name (last, first, middle initial)	Department/Title

Home Address	Phone Number

Supervisor's Name	Supervisor's Phone Number

ACCIDENT INFORMATION

Injury Time	Time Work Began	Last Paid Work Day	Date University Notified	Salary Continued	Date Returned to Work	Number of Days Worked/Week
				☐ Yes ☐ No		

Incident Type (burn, foreign body, sprain, fracture, etc.)

Body Part (specify right or left side, head, neck, trunk, etc.)

Injury Occurred on University Property	Zip Code of Incident/Injury
☐ Yes ☐ No	

Brief Description of Injury/Incident

Describe The Work Process The Employee Was Doing At The Time The Injury/Illness/Incident Occurred

List All Equipment, Materials The Employee Was Using Or Working With At The Time Of Incident

Witness Names	Witness Phones	Witness Names	Witness Phones

Safeguards Provided ☐ Yes ☐ No	Safeguards Used ☐ Yes ☐ No	

Building or Site Location of Injury	Location in Building/site (hallway, bathroom, stairs, landscape, street, etc.)

MEDICAL TREATMENT

Initial Treatment

☐ No Medical Treatment ☐ Minor: By Employer ☐ Minor Clinic Hospital

☐ Emergency Case ☐ Hospitalized > 24 ☐ Future Major Medical Lost Time Anticipated

Name of Treating Physician, Clinic or Hospital

Address (street, city, state, zip)

Supervisor's Signature or Typed Name	Date

UM WC-1 (FEB 16) 2/3/2016

Submit Form