OZARKS TECHNICAL COMMUNITY COLLEGE

Employee Report of Injury or Illness

(To be used for Worker's Compensation)

Please return completed form to the Office of Administrative Services.

Part 1: Employee Information

Name ____ Sex _______ Race ______

Last First Middle Initial

Address ________________________________ City ____________ State ____ Zip _____

Date of Birth ___/___/___ SSN ___________________ OTC I.D. # ____________________

Home Phone _______________ Cell Phone _______________ Email ___________________

Department _______________ Job Title ___________________ Employee ☐ P/T ☐ F/T

Supervisor _____________________ Shift/Start Time ___________ Date of Hire __________

Part 2: Incident Information

Date of Incident _______________ Time of Incident ________ Date Reported _______________

Incident Location ____________________________________ Employer Premises ☐ Yes ☐ No

Specific description of incident and how it occurred (include as much detail as possible) ________________

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____

Treatment given or other action taken ____

____

Safeguards or safety equipment provided to prevent injury __________________________________

Physician/Location providing treatment ____

Declining Medical Coverage/Worker's Compensation Benefits Yes No

Signature confirming declining of coverage: ____________________________ *Date:* ________

Part 3: Witness to Incident

Name(s) ____

Address(es) ____

Phone(s) ____

Person filing report __________________________ *Date* ______________________

Office Use

Hire Date _______________ Workers Comp Representative ________________________

Gross Pay/Week ___________ Date Workers Comp Contacted ____________ Reference # __________________