

EMPLOYEE'S WORK

INJURY AND ILLNESS REPORT

UW-
UWS/OSLP-1Emp (03/02)

PLEASE TYPE OR PRINT

FOR AGENCY USE ONLY	
Claim Number	
Claim Examiner / Representative	

INSTRUCTIONS:

1. Complete within 24 hours of the injury.
2. Sign and date the completed report
3. Submit to your supervisor to complete the WKC-12 form.
4. Direct any questions to your agency Worker's Compensation Coordinator.

Employee Name (as it appears on payroll)		Time of Injury	AM PM	Date of Injury	
Work Telephone ()	Home Telephone ()	Social Security Number *			
Was Medical Treatment Required? First aid only Time Lost From Work Last day worked (MM / DD/ YY)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Address of Treating Practitioner/Facility			
Exact location of where accident took place (inside, outside, building name, room, vehicle, etc.)					
Witnesses (names, addresses, work telephone numbers)					
Describe in <u>detail</u> what you were doing when the injury /illness occurred. How exactly did it happen?					
Date the injury / illness reported to my supervisor (Month, Day, Year)					
Part of body injured (Check ALL that apply, and circle appropriate position) (Thumb = Finger 1, Great toe = Toe 1)					
Abdomen	Back U M L	Finger R L 1 2 3 4 5	Head	Mouth	Shoulder R L
Ankle R L	Eye R L	Foot R L	Knee R L	Neck	Toe R L 1 2 3 4 5
Arm R L	Elbow R L	Hand R L	Leg R L	Nose	Wrist R L
Other (Please specify)		For Hand and Arm injuries circle your dominant arm : Right Left			
Have you ever been treated for a similar injury or condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes Date(s) of Treatment	Name of Practitioner, Hospital or Clinic Which Provided Prior Treatment for Similar Injury:			

Please read carefully. I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination from employment. Further I understand that the signature below authorizes medical, mental health and chiropractic providers to release all medical, mental health and chiropractic records to the State of Wisconsin, University Of Wisconsin System, Office of Safety and Loss Prevention, Worker's Compensation Department, or its designated representatives, at P.O. Box 8010, Madison, WI 53708-8010

Employee Signature _____ **Date** _____

FOR AGENCY USE ONLY	PRIMARY ORGANIZATION CODE		FUND NUMBER	%	
	1-2-85-0 - - - - -				
	SECONDARY ORGANIZATION CODE		FUND NUMBER	%	
	1-2-85-0 - - - - -				
LOSS DESCRIPTION CODES	CAUSE / OCCURRENCE	OBJECT	RESULT	LOCATION	OCCUPATION
OSHA CODES	Incident was OSHA "recordable"? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name of Authorized Representative			Date		

*Your Social Security Number must be provided and will be used for positive identification in the processing of any claims.