

Work~Connections

Employee-Centered Illness and Injury Support Services

University of Michigan
400 S. Fourth St.
Argus II Bldg.
Ann Arbor, MI 48103-4816

Illness or Injury Report Form

- Non-Work Related Illness or Injury **Contract Worker (non U of M payroll)**
 Work Related Illness or Injury **Work-related illness/injury**
 Certification of Medical Condition Only **(for MIOSHA reporting purposes only)**

ANN ARBOR (734) 615-0643
TOLL-FREE 1-877-869-5266 (UMWKCON)
FAX (734) 936-1913
Submit Claim to EMAIL WorkConnect.Claims@umich.edu
WEB SITE <http://www.umich.edu/~connect>

Please follow directions on how to submit Risk Management Services forms.

State law requires the employer to provide medical care at a designated medical facility. Within the first 10 days the employee is required to treat at the employer's dedicated medical facility. If you need the name of a designated medical facility, call Work~Connections. For serious incidents, please call Work~Connections immediately. Complete and submit this form within 24 hours of notification of injury.

Faculty or Staff Member Information. Complete this section for ALL illness or injury

Faculty or Staff Member Name (Last, First, Middle Initial)		Today's Date
Home Street Address		EMPL ID# (UM ID)#
City	State	Zip + 4 digits
Social Security Number (mandatory)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male
Home Phone Number (include area code)	Work Phone Number	Date of Hire
Department Name <u>and</u> Department Code	Occupation	Employment <input type="checkbox"/> Regular <input type="checkbox"/> Temporary
Supervisor's Name (please print)	Supervisor's Phone Number	Supervisor's Pager Number
Was this person out of work due to the illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give dates:	Has this person returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Were there restrictions on the work he or she could do? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last Date Worked _____ Date Returned to Work _____	If yes, describe Have those restrictions been accommodated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What happened to cause injury or illness?		Scheduled Workdays (Check) <input type="checkbox"/> <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU <input type="checkbox"/> Day <input type="checkbox"/> Afternoon <input type="checkbox"/> Midnights

Injury/Illness Information. Complete this section only for Work Related illness or injury

When did the incident occur or the illness begin? Date _____ Time _____ A.M. P.M.	Name of Witness _____ Phone Number _____
When did the employee first report the incident or illness to the department? Date _____ Time _____ A.M. P.M.	Who was it reported to? _____ Title _____ Phone Number _____
Location of incident (be specific)	Did incident involve a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No
Nature of injury or illness (for example: contusion, burn, strain)	Part of body directly affected by the injury or illness (for example: hand, arm, circulatory system)
Describe the events which caused the injury or illness (for example: fall, puncture, chemical exposure)	Name of object or substance which directly injured the employee (for example: knife, needle, patient)
Treating Facility (check one): <input type="checkbox"/> MWorks <input type="checkbox"/> EHS <input type="checkbox"/> ER Other _____	Was treatment declined? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly Describe Treatment	Describe actions taken by supervisor to prevent recurrence of this incident
Supervisor's Signature _____ Date _____ Fax _____	