Supervisor/Instructor Report of Employee/Student Injury

Date of Report: Date of Injury: Time of Injury:

Name of Injured :

Affiliation: Employee ☐ Student ☐ Note: if the injury occurred to a student while on work-study, the student is considered an employee and is covered by workers compensation.

NU ID#

If Employee, provide Job Title:

Is Employee: Full Time ☐ Part Time ☐ What time did the shift begin?

Did the Employee miss workdays after the injury? Yes ☐ No ☐

If yes, provide date of return to work if applicable:

Employee Department or Class the Student was attending (if applicable):

Describe the injury/illness:

Describe the Injury/Illness (including **how**, **where**, and **why** specifically it occurred):

Were there witnesses to the incident? Yes ☐ No ☐

If yes, please provide names and phone numbers if available:

Was injured seen by UNO Health Services or other medical professional? Yes ☐ No ☐ Other ☐

If Other, please provide medical facility, attending physician and date of visit.

Supervisor/Instructor Name:

Department Phone Number E-mail Address

Please save this completed form and submit to Stan Schleifer, EAB 211, sschleifer@unomaha.edu; Jamal Khan, EAB 211, jamalkhan@unomaha.edu; and Mary Razor, EAB 205, mrazor@unomaha.edu