SUPERVISOR'S REPORT OF EMPLOYEE INJURY

UNIVERSITY OF NEBRASKA AT OMAHA

1. EMPLOYEE'S NAME:
2. Date & Time of Injury: AM ☐ PM ☐
3. Personnel #
4. Job Title:
5. Department:
6. Employee's scheduled work week: Full-Time ☐ Part-Time ☐

   Hours/Day Days/Week

   When did shift begin? AM ☐ PM ☐
7. Was Employee Paid for Day(s) Injured? Yes ☐ No ☐
8. Has Employee returned to Work? Yes ☐ No ☐ If Yes, when?
9. Describe injury and how it occurred.

   ☐ Check Here if information is on attached Health Services Report.
10. Specific place where injury occurred: (bldg., parking lot, classroom, etc.)
11. Does the injury restrict normal work performance? Yes ☐ No ☐ If Yes, in what way?
12. Were there any witnesses to the incident? Yes ☐ No ☐

    If yes, provide name and phone number
13. Was Employee **seen** by a physician? Yes ☐ No ☐

    If yes, name of physician (please print):

    Physician's Diagnosis

    Name of medical facility (please print):
14. Was Employee seen by Health Services? Yes ☐ No ☐
15. Supervisor's Name:

    Supervisor's Signature:

    Supervisor's Title:

    Date:

Please return the report to: gborowicz@unomaha.edu

EHS USE ONLY:

First Aid ☐ Lost Time Injury ☐

Medical Treatment ☐ Total Lost Time

Restricted Activity ☐

UNO Safety Officer _____