NEBRASKA
Good Life. Great Service.
DEPT. OF ADMINISTRATIVE SERVICES

UNO Employee Incident Report

This form must be completed, reviewed with a supervisor and submitted to Environmental Health and Safety (EHS) and Human Resources Risk Management within 24 hours

Employee Name (last, first)_____ NUID#: _____

Address (Home): _____ Job Title:_____Hire Date _____

City:_____State:_____Zip: _____ Department:_____

Employee Phone Number: _____ Supervisor Name & Number: _____

Date of Injury/Illness:_____ Time Employee Began Work:_____ Time of Injury/Illness: _____

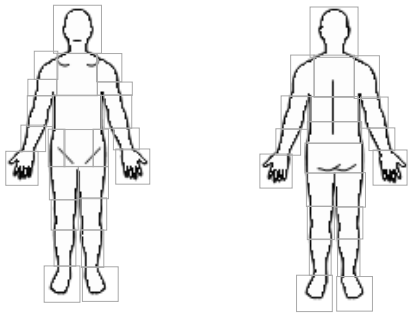
Location of Incident: _____ Who was Notified? _____

Date Employer Notified: _____ Last Work Day: _____ Loss time ☐ Yes ☐ No

Body Part Injured:_____ If Fatal, Date of Death: _____

Describe incident (describe what happened, how the incident occurred, include details pertaining to equipment, environment, tasks, etc.)

Indicate on the Diagram the location of injury



Injury is a: ☐ New or ☐ Re-injury

Initial Treatment:

No Medical Treatment: ☐
First Aid by Employer: ☐
Minor Clinic/Hospital: ☐

Emergency Room: ☐
Hospitalized Overnight: ☐
Hospitalized >24 Hours: ☐

What was the cause of this incident?

_____

How could this incident have been prevented?

_____

_____

Did anyone witness the incident? ☐ Yes ☐ No

If yes, please provide the name and phone number of the witnesses.

_____

_____

Do you have other employment? ☐ Yes ☐ No If yes, where? _____

Employee Signature Date

Supervisor Signature Date

Please return completed incident report to:
Environmental Health & Safety at uno.ehs@nebraska.edu **AND** Human Resources at uno.hrriskmanagement@nebraska.edu

Form updated 03/12/26