EMPLOYEE DESCRIPTION OF INJURY FORM

Date of injury: _________________ Time of injury: _________________ AM/PM

Date injury was reported: _________________ Reported to _________________

PSU ID #_____________________

Name of Injured Person (Please Print): _______________________________________

Address: ___________________________________________________________________

Phone Number(s) ___________________ Date of Birth: _________________ Male_____ Female_____

Type of Injury: __________________ Body Part(s) affected__________________________

Details of injury
1. Please describe in your own words how the injury occurred. Include specific details such as equipment used, tools, etc. (Please Print)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

2. Please describe where the injury occurred and what activity you were performing when the injury occurred. (Please Print)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

(Continue on the back of this form to add additional details.)

Witness to the injury: ________________________________ Name ________________________________ Contact Number ________________________________

Signature of Employee __________________________________________ Date: __________________________

MAIL COMPLETED FORM PROMPTLY TO PENN STATE WORKERS’ COMPENSATION, 410 JAMES M. ELLIOTT BUILDING, UNIVERSITY PARK, PA 16802.

For Workers’ Compensation Use Only:

Claim Number ________________________________

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