

PENNSTATE



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 \_\_\_\_\_