DEPARTMENT OF NATURAL RESOURCES
WORK RELATED INJURY/ILLNESS REPORT FORM
(Use this form to document a work related injury or illness.)

Injured employee: _____________________________________________

Employee Identification Number (EIN) or Social Security Number: ____________________________

Resident mailing address: ____________________________

Home or Cell phone: __________________ Work phone: ____________________ Sex: Male ___ Female ___

Date of birth: __/__/______ Marital status: Unmarried ___ Married ___ Hire Date: __________

Job (Position) title: _____________________________________________

Work Location: _____________________________________________

Employment status: Full Time ___ Part Time ___ Temporary ___ Permanent ___ Number of dependents: _______

Hourly wage rate (at time of incident): $________ Number of days worked per week: ______

Did you receive full pay for the day of injury? Yes ___ No ___ Did your salary continue after incident? Yes ___ No ___

Time you began work the day of the incident: _____:____ a.m. ___ p.m. ___

Date of injury/illness exposure: __/__/______ Time of injury/illness exposure: _____:____ a.m. ___ p.m. ___

Date employer was notified: __/__/______ Date disability began: __/__/______

Direct supervisor: _____________________________________________

Type of injury/illness (eg. Sprain, laceration, break, etc.): _______________________________________________________

Part of body affected: _____________________________________________ Left side: ___ Right side: ___ Both Sides: ___

Did injury/illness exposure occur on state property? Yes ___ No ___ Did it result in lost time: Yes ___ No ___

Location of accident/illness exposure: ____________________________

List all: equipment, materials, and chemicals being used when the accident/illness or exposure occurred.

______________________________________________________________

______________________________________________________________

Describe specific activity you were engaged in when the accident/illness exposure occurred.

______________________________________________________________

______________________________________________________________

Describe your assignment at the time the accident/illness exposure occurred.

______________________________________________________________

______________________________________________________________
How did the injury/illness or exposure occur? Describe the sequence of events and objects or substances that directly injured the employee or made the employee ill.

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Was safety equipment provided? Yes ___ No ___
Was safety equipment being used? Yes ___ No ___

Initial Treatment: None ___ (Notify Human Resources immediately if you receive medical treatment sometime in the future)
Minor by employer ___ Minor by clinic/hospital ___ Emergency care ___
Hospitalized 24 hours: Yes ___ No ___ Future major medical/lost time anticipated: Yes ___ No ___

Health care provider (Treating Physician): ____________________________________________________________
Name

Address of health care provider: ________________________________________________________________
Street City State Zip Code

Name of hospital (if used): _________________________________________________________________

Address of hospital (if used): ________________________________________________________________
Street City State Zip Code

Witnesses: ____________________________________________________________
Name Phone Number

Supervisor’s comments: _________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Employee Signature or Designee (person completing form) Date

Complete this form as soon as possible after the accident or onset of the illness and send or deliver it to the Department’s Human Resource Office.

- Physical Address: 1594 West North Temple, Suite 316, Salt Lake City, Utah
- Mailing Address: Department of Natural Resources, Human Resource Office, P.O. Box 145610, Salt Lake City UT 84114
- FAX: 801-538-7219
- E-mail: nrhractions@utah.gov

Call the Human Resource Office at 801-538-7318 if you have questions or need assistance in completing this form.