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

Injured employee: _____
Last Name *First Name* *Middle Name or Initial*

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

Resident mailing address: _____
Street *City* *State* *Zip*

Home phone: _____ **Work phone:** _____ **Cell phone:** _____

Date of birth: _____ /_____ /_____ **Sex:** Male ___ Female___ **Marital status:** Unmarried ___ Married ___
mm dd yyyy

Job (Position) title: _____

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. ___
mm dd yyyy

Date employer was notified: _____ / _____ / _____ **Date disability began:** _____ / _____ / _____
mm dd yyyy *mm dd yyyy*

Direct supervisor: _____ _____
Name *Phone*

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: _____
Street *City* *State*

List all equipment, materials, and chemicals being used when the accident/illness 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 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: _____
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: _____

_____

_____

_____

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 801-538-7210 if you have questions or need assistance in completing this form.