Capital University

Human Resources Office
1 College and Main Street
Columbus, OH 43209

Initial Injury Report

Employee Information			
Name:	Social Security Number:		
Position:	Department:	Sex:	Age:

Injury Information			
Date of Injury:	Date Reported:	To Whom:	
Where Did Injury Occur?			
Describe Injury in Detail:			
What Caused Injury:			
Was First Aid Required?	☐ YES ☑ NO	Was Hospital or Doctor Treatment Required?	☐ YES ☐ NO
Will Injury Cause Loss of Time?	☐ YES ☐ NO	For How Long?	
When is Employee Expected to Return to Work?			
Name of Person Giving Initial Treatment:			
Name(s) of Witnesses:			
What Has Been Done to Prevent a Recurrence?			
Date Prepared:		By Whom:	Title:
Supervisor's Appraisal and Recommendations:			
Supervisor's Signature:		Date:	

FORWARD TO HUMAN RESOURCES OFFICE