

DREXEL UNIVERSITY REPORT OF EMPLOYEE INJURY

Answer all questions fully. If not applicable, reply N/A

EMPLOYEE INFORMATION

NAME:	GENDER: Male: ☐ Female: ☐
ADDRESS:	City State/Zip
0001	g Zip Code otherwise claim cannot be processed)
HOME PHONE: ()	CELL PHONE: ()
DATE OF BIRTH:/ SSN: _	
MARITAL STATUS: Single	
OCCUPATION:	DEPT:
WORK PHONE #: ()	DATE OF HIRE AT DREXEL://
EMAIL ADDRESS:	
PAYROLL SCHEDULE: Monthly Bi-Weekly Weekly	LAST FULL DAY PAID:
WORK SCHEDULE:(example: M-F, 8:00am	Full time Part time - 5:00pm) Hours per week:
ACCIDENT INFORMATION	
DATE OF INJURY:	TIME OF INJURY: (example: 1:00pm)
DATE ACCIDENT/INJURY REPORTED:	
DATE OUT OF WORK:	DATE RETURNED TO WORK:
PERSON INJURY REPORTED TO:	
EXACT LOCATION OF INCIDENT:	
WHAT YOU WERE DOING WHEN INJURY OCC	CURRED:

HOW DID INJURY	OCCUR?:			
CHECK ONE:	UNSAFE ACT	MECHANICAL DEFECT	OTHER	
LIST NAMES OF V	VITNESSES:			
	MEDICAL TREATMENT CATION OF INJURY OR DIS	SEASE (Specify part of body):		
DATE TREATMEN	IT FIRST SOUGHT:	CHECK HERE IF [DID NOT TREAT	
NAME OF PHYSICIAN or PLACE OF TREATMENT:		☐ ER** ☐ Occupa	— —··	
ADDRESS OF ATT	ΓENDING PHYSICIAN OR Η	HOSPITAL:		
		llow-up with Oc. Medicine within 48 ho re Monday through Friday from 7:30al		
EMPLOYEE'S SIG	NATURE:	DATE	:	
SUPERVISOR'S S		to employee's signature)	i:	
Supervisor's Name	e (please print):			

PLEASE FORWARD A COPY OF THIS FORM TO:

Office of Risk Management

The Left Bank 3180 Chestnut Street, Suite 101 Philadelphia, PA 19104

Beverly Perrone Risk Management Coordinator Phone: (215) 895-2149 Fax: (215) 571-4518

Employees injured while working within the scope of their employment are eligible for worker's compensation. Worker's compensation will pay for all relevant medical and diagnostic treatment, as well as compensate employees unable to work due to their injury, within certain time limits. Please contact the Drexel Risk Manager for details.