University of Missouri
Report of Injury

This form should be completed for all employees injured on the job. The Supervisor should complete the report within 24 hrs of employee’s Injury. Please press submit button at bottom, fax (573.882.7861) or email to umrimwccclaims@umsystem.edu

EMPLOYEE INFORMATION

Date of Incident  Employee Number  Campus

☐ Columbia  ☐ Kansas City  ☐ Rolla  ☐ St Louis  ☐ UM System  ☐ Hospital

Name (last, first, middle initial)  Department/Title

Home Address  Phone Number

Supervisor’s Name  Supervisor’s Phone Number

ACCIDENT INFORMATION

Injury Time  Time Work Began  Last Paid Work Day  Date University Notified  Salary Continued  Date Returned to Work  Number of Days Worked/Week

Injury Type (burn, foreign body, sprain, fracture, etc.)

Body Part (specify right or left side, head, neck, trunk, etc.)

Injury Occurred on University Property  Zip Code of Incident/Injury

☐ Yes  ☐ No

Brief Description of Injury/Incident

Describe The Work Process The Employee Was Doing At The Time The Injury/Illness/Incident Occurred

List All Equipment, Materials The Employee Was Using Or Working With At The Time Of Incident

Witness Names  Witness Phones  Witness Names  Witness Phones

Safety Provided  ☐ Yes  ☐ No

Safety Used  ☐ Yes  ☐ No

Building or Site Location of Injury  Location in Building/site (hallway, bathroom, stairs, landscape, street, etc.)

MEDICAL TREATMENT

Initial Treatment

☐ No Medical Treatment  ☐ Mnr: By Employer  ☐ Mnr: Clinic Hospital

☐ Emergency Case  ☐ Hospitalized > 24  ☐ Future Major Medical Lost Time Anticipated

Name of Treating Physician, Clinic or Hospital

Address (street, city, state, zip)

Supervisor’s Signature or Typed Name  Date

UM WC-1 (FEB 16) 2/3/2016

Submit Form