**State of Wisconsin**
**University Of Wisconsin System**
**UW-**
UWS/OSLP-1Emp (03/02)

# EMPLOYEE'S WORK
# INJURY AND ILLNESS REPORT

| *FOR AGENCY USE ONLY* |
|---|
| Claim Number |
| Claim Examiner / Representative |

Please Type or Print
**INSTRUCTIONS:**
1. **Complete within 24 hours of the injury.**
2. **Sign and date the completed report**
3. **Submit to your supervisor to complete the WKC-12 form.**
4. **Direct any questions to your agency Worker's Compensation Coordinator.**

| Employee Name (as it appears on payroll) | | Time of Injury AM ☐ PM ☐ | Date of Injury |
|---|---|---|---|
| Work Telephone ( ) | Home Telephone ( ) | Social Security Number * | |
| Was Medical Treatment Required? ☐ Yes ☐ No<br>First aid only ☐ Yes ☐ No<br>Time Lost From Work ☐ Yes ☐ No<br>Last day worked (MM/DD/YY) | | Name and Address of Treating Practitioner/Facility | |

Exact location of where accident took place (inside, outside, building name, room, vehicle, etc.)

Witnesses (names, addresses, work telephone numbers)

Describe in detail what you were doing when the injury /illness occurred. How exactly did it happen?

Date the injury / illness reported to my supervisor (Month, Day, Year)

Part of body injured (Check ***ALL*** that apply, and circle appropriate position) (Thumb = Finger 1, Great toe = Toe 1)

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | Abdomen | ☐ | Back | U | M | L | ☐ | Finger | R | L | 1 2 3 4 5 | ☐ | Head | ☐ | Mouth | ☐ | Shoulder R L |
| ☐ | Ankle R L | ☐ | Eye | R | L | | ☐ | Foot | R | L | | ☐ | Knee R L | ☐ | Neck | ☐ | Toe R L 1 2 3 4 5 |
| ☐ | Arm R L | ☐ | Elbow | R | L | | ☐ | Hand | R | L | | ☐ | Leg R L | ☐ | Nose | ☐ | Wrist R L |
| ☐ | Other (Please specify) | | | | | | | | | | | | | | | | |

For Hand and Arm injuries circle your dominant arm : Right ☐ Left ☐

| Have you ever been treated for a similar injury or condition? ☐ Yes ☐ No | If Yes Date(s) of Treatment | Name of Practitioner, Hospital or Clinic Which Provided Prior Treatment for Similar Injury: |
|---|---|---|

***Please read carefully.*** I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination from employment. Further I understand that the signature below authorizes medical, mental health and chiropractic providers to release all medical, mental health and chiropractic records to the State of Wisconsin, University Of Wisconsin System, Office of Safety and Loss Prevention, Worker's Compensation Department, or its designated representatives, at 780 Regent St., Madison, WI 53715

✍ **Employee Signature** _____ **Date** _____

| **FOR AGENCY USE ONLY** | **PRIMARY ORGANIZATION CODE** | **FUND NUMBER** | **%** |
|---|---|---|---|
| | 1-**2 8 5**-**0** ___ - ___ ___ - ___ ___ ___ ___ ___ ___ ___ | | |
| | **SECONDARY ORGANIZATION CODE** | **FUND NUMBER** | **%** |
| | 1-**2 8 5**-**0** ___ - ___ ___ - ___ ___ ___ ___ ___ ___ ___ | | |

| **LOSS DESCRIPTION CODES** | **CAUSE / OCCURRENCE** | **OBJECT** | **RESULT** | **LOCATION** | **OCCUPATION** |
|---|---|---|---|---|---|
| | ___ ___ ___ ___ | ___ ___ ___ | ___ ___ ___ ___ | ___ ___ ___ | ___ ___ ___ ___ |

| **OSHA CODES** | Incident was OSHA "recordable"? ☐ Yes ☐ No |
|---|---|
| Name of Authorized Representative | Date |

***Your Social Security Number must be provided and will be used for positive identification in the processing of any claims.