Indiana University Health

EMPLOYEE INJURY / EXPOSURE REPORT

All IU Health Employee Injuries / Exposures should be reported on this form.

Name:				
Employee SS# (Required):	Date of Birth:	Sex: ☐ M ☐ F	Other Last Name(s) used:	Empl. ID#:
Street Address:	Home Phone#:		Job Title:	Date Hired:
City/State/Zip:	Work Phone#:		Department (Regular work area) and Cost Center#:	
Please Name regular work location:				
Incident Information (to be completed by employee)	Date of incident:	Time: ☐ AM ☐ PM	Location of incident if different from above:	
List Name(s) of Witnesses:	Shift Start Time: ☐ AM ☐ PM		Date & Name of Immediate Supervisor Reported to:	
What Part(s) of Body was Injured (be specific):	Side: ☐ L ☐ R	Type of Injury/illness (Contusion, Sprain, Exposure):		

Give a Complete Description of How the Incident occurred – Describe what exactly what you were doing at the time of incident:

Do you claim that this injury/illness is caused by your work at Indiana University Health? _____YES_____NO. . If yes then please read and date this report.

I authorized any physician, surgeon or other person who has treated me or whom I have consulted for any purpose and any hospital or institution which have been treated, examined or confined to divulge and make available to Indiana University Health or their designated representative any and all information concerning my current injury/ illness, including all psychiatric and psychological information and tests. This authorization shall be valid for one year from the date shown below. A photocopy of this authorization shall be as valid as the original.

Employee Signature: Date Completed / Signed:

Exposure Information Must be completed by employee	Brand of Device Used during Exposure:		Type of Device Used :	Gauge:
Source Patient Name/Room#:	Source Pt. Hospital#	Treating MD Name:	WC/EOHS STAFF USE ONLY:	
Supervisor Statement (completed by Immediate Supervisor)	Supervisor/Mgr Name and Title (Print):		Work Phone:	
			Pager:	
			Mobile:	

I have discussed the Instructions Section with the employee and instructed the employee to seek care at the appropriate IU Health facility and instructed them regarding follow-up. Any comments please contact the WC Claim Consultant (see Facility Sheet).

Supervisor Signature:	Date Received form:

Medical Provider Statement	Preliminary Diagnosis:	
Signature & Date Seen: Employee to be instructed to follow up with the IU Health Occ. clinic the next business day after treatment which must occur at an approved IU Health medical facility.	Work Status / Restrictions / Comment:	
Below is WC Use Only	Claim Recording:	WC Note:
OSHA Case#	Checked and/or Entered by: Date:	WC Claim Consultant Signature Date:
STARS #:		

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INSTRUCTIONS

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I. Employees shall use this form to report all work related injuries or illnesses. This form shall be completed by employees as soon as possible and given to a supervisor for further action. Employee must contact Employee Health or Worker Compensation office on the next business day. Employee is responsible for following each employer specific work location policies and procedures. The form shall be signed and dated

II. Supervisor should sign & date form on the date you receive completed form. Give employee a copy to take to an Indiana University Health approved medical provider. Original copy must go to Indiana University Health Worker's Compensation Department..

III. Blood, Body Fluid Exposures shall follow your facility specific instructions concerning exposures to body fluids and blood.

IV. Incidents that you feel are work-related needs to be reported to your supervisor immediately and an Employee Injury/Exposure Report form needs to be completed.

Employee Injury/Exposure Report Form is available on PULSE/Departments/Worker's Compensation. Please be aware that medical bills for services may not be considered until a completed, signed, dated form is received in the Indiana University Worker's Compensation Department.

Indiana University Health requires the reporting of any injury or illness immediately, or as soon as practical to the appropriate Employee Health clinic or claim may be delayed or denied. Please refer to your location specific instructions.

V. All Incidents/Exposures medical treatment must be coordinated through the appropriate Employee Health facility. If you choose to seek medical treatment with your own choice of physician at a non-approved medical facility, it may not be covered or paid by Indiana University Health Worker's Compensation.

VI. Please note that any care beyond initial first aid visit must be pre-approved and scheduled by the Indiana University Health Worker's Compensation Claim Consultant/Department staff.

VII. Contact information:

- Indiana University Health Worker's Compensation
- 340 West 10th Street. Suite 3100
- Indianapolis, Indiana 46202
- Email Address: workerscomp@iuhealth.org
- Fax Number : (317) 968-1318
- Telephone: (317) 963-7838