



FILE WITHIN 5 DAYS OF INCIDENT. (In the event of a serious or fatal injury or illness, notify within 24 hours. It is the supervisor's responsibility to report lost time due to an occupational injury or disease. Failure to do so immediately may result in departmental fines. NOTE: PLEASE FILL IN EACH BLANK)

OCCUPATIONAL ACCIDENT OR ILLNESS REPORT

Name _____ SSN _____

Address _____ Zip _____

Home Phone () _____ Sex ___ Race ___ Date of Birth _____

Marital Status _____ No. of Children Under 18 _____ Date of Hire _____

Department (Name) _____ Budget Code _____ Title Code _____

Date of Injury _____ Time of Injury _____ Normal Starting Time _____

Did the employee miss work due to this accident/illness? Yes ___ No ___

Date Returned to Work _____ Time Returned to Work _____

Date Employer Knew _____ Supervisor _____

Mech Defect? Y ___ N ___ Same Wage? Y ___ N ___ Empl Premises? Y ___ N ___

Work Phone Number _____ Unsafe Act? Y ___ N ___ Hourly Salary \$ _____

Exact Location of Injury (Building, etc.) _____

Nature of Injury or Illness _____

Physician and Address _____

Diagnosis: _____ Diagnosis Date: _____

How Did Injury Occur? _____

Activity When Injured _____

Corrective Action Taken _____

Recommend Formal Accident Review? Y ___ N ___

SEND COPIES TO:

Office of Public Safety & Risk Management
Suite 124 Public Safety Building
South Stadium Road
Baton Rouge, Louisiana 70803-7907
Phone (225)578-3285/Fax (225)578-3577

Occupational and Environmental Safety
Suite 126 Public Safety Building
South Stadium Road
Baton Rouge, Louisiana 70803-7910
(225)578-5640/Fax(225)578-7489

Reporter's Name & Telephone Number

Supervisor's Signature

Date of Report _____

Revised 06/02

Phone _____