OU Employee's Report of On-the-Job Injury/Illness

to be completed by the employee only - please provide full details where applicable – please use black ink only

Legal Name of Employee:	**Social Security #:**
Home Address:	**Home Phone Number(s):**
Work Phone Number(s):	**Birth Date:**

Date of Your Injury:	**Time of Your Injury:** am pm	**Time You Reported to Work:** am pm
What job were you performing at the time of your injury?		
Please describe how your injury occurred – give complete details:		
Was there anything that could have been done to prevent your injury?		
What are your injuries and what part(s) of your body are affected?		
Please provide the names of anyone else who was with you at the time you were injured:		

Employee's Signature **Date Signed**

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and true. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Retain a copy of this report and give the original to your Supervisor.

Form Revised 2/1/00