



THIS INJURY AND ILLNESS INCIDENT REPORT IS ONE OF THE FIRST FORMS THAT MUST BE FILLED OUT WHEN A RECORDABLE WORK-RELATED INJURY OR ILLNESS HAS OCCURRED. PLEASE FOLLOW THE FORM INSTRUCTIONS CAREFULLY.

- **PLEASE NOTE:** The form **must be** printed on **one sheet** of paper with the first page of the form printed on the front and the second page of the form printed on the back.
- This form, along with the OSHA's Form 301 – Injury and Illness Incident Report, should be completed as soon as possible after an accident or illness.
- This form should be typed.
- This form must be used exclusively by all state employees in presenting claims for workers' compensation. All questions must be answered.
- Question 4 – State Agency should be “ ETSU- ” department name.
- Question 5 – Office Address should be “807 University Pkwy, Box” and the box number of the department.
- Upon completion, please sign and return the completed form to:

HUMAN RESOURCES
BOX 70564

Your assistance in completing this form correctly is appreciated.

TO BE COMPLETED BY SUPERVISOR:

1. What position did employee hold when injured? _____
2. Was injury caused by (a) employee's willful misconduct? _____
(b) intentional self-inflicted injury? _____
(c) intoxication? _____
(d) failure or refusal to use safety appliance furnished him? _____
(e) failure to perform a duty required by law? _____
3. When was first notice of injury given to employer? Date _____ Time _____
To Whom? _____ Position _____
4. Monthly salary on date of injury \$ _____
5. If disabled, will employee be on leave without pay during disability? _____
6. Relate any knowledge you may have of injury or what the employee reported to you _____

We, the undersigned, certify that all statements contained herein and on any attachments hereto are true and that the injuries reported were actually incurred. We also acknowledge that it is a misdemeanor to file a false claim with the Division of Claims Administration.

Claimant

Date

Supervisor

Date