

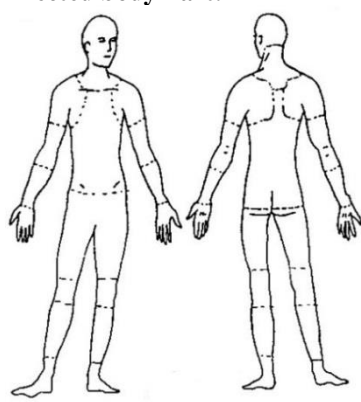
## EMPLOYEE REPORT OF INJURY/ILLNESS

**Instructions:** This form should be completed by the injured employee following an incident that results in injury or illness. The form should be completed as soon as possible (within 24 hours) and submitted to the employee's immediate supervisor or supervisor's designee. **Supervisor should review and sign the form and forward to HR by faxing to 470-578-9174 or by scanning and e-mailing to [benefits@kennesaw.edu](mailto:benefits@kennesaw.edu).**

### Injured employee (To be completed by each injured employee)

First Name				Last Name		
Employee ID #			Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	
Home address:					Tel #	
City			State			Zip Code
Job Title				Department		
Supervisor Name					Supervisor Tel #	
<b>Employment Type</b>	<b>Employment Category</b>		<b>Length of Employment</b>			
<input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Student	<input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Temporary		<input type="checkbox"/> 1-6 mos. <input type="checkbox"/> 1 yr. – 5 yrs.		<input type="checkbox"/> 6 mos. – 1 yr. <input type="checkbox"/> more 5 yrs	

### Describe the incident

Date of Incident			Time of the incident			Shift	<input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup>
Location of the Incident (Address)			Specific Location of the incident (e.g office, mechanical room, shop)				
Did the incident involve property damage?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Was a motor vehicle involved in this incident?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Affected body Part:</b> 	<input type="checkbox"/> Head/face <input type="checkbox"/> Eye <input type="checkbox"/> Neck/shoulder <input type="checkbox"/> Arms/elbow <input type="checkbox"/> Wrist/Head <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Fingers <input type="checkbox"/> Chest/lower trunk <input type="checkbox"/> Rib <input type="checkbox"/> Hip <input type="checkbox"/> Back <input type="checkbox"/> Leg/knee <input type="checkbox"/> Foot/ankle <input type="checkbox"/> Toes <input type="checkbox"/> Other _____		Do you require medical attention			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
			Name of your treating physician				
			Contact information of your physician				

Describe, step-by-step, how the incident occurred:

What would you recommend to prevent this accident from recurring:			
Have you reported the incident to your supervisor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date the incident was reported to supervisor	
If you did not report to supervisor, who did you report to?		Date reported	
Names of witnesses, if any. (Witness report must be completed)			
<b>Signatures</b>			
Employee's Signature		Date	
Supervisor's Signature		Date	



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## WORKER'S COMP. LEAVE ELECTION FORM

To be remitted to:

Department of Administrative Services (DOAS)  
Risk Management Division  
Worker's Compensation  
200 Piedmont Ave., SE Suite 1208 West  
Atlanta, GA 30334

**Name of Injured Employee:** \_\_\_\_\_ **Dept.:** \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_

I was injured on the job at Kennesaw State University. If I lose time from work due to this injury, I request that I be paid as follows: (check one)

From my accumulated sick leave followed by my accumulated vacation leave before receiving Worker's Compensation benefits for loss of wages. I understand that after I have exhausted my accumulated sick and vacation leave, I will receive Worker's Comp. benefits if the doctor determines I am still unable to work due to this injury.

From Worker's Compensation benefits for loss of wages if the doctor determines I am unable to return to work instead of receiving full pay from sick and vacation leave. I understand I will not be paid for the first seven (7) days unless I am out a minimum of twenty-one (21) days according to Georgia State Worker's Comp. law.

From my accumulated sick leave followed by accumulated vacation leave through \_\_\_\_\_ (date), at which time I wish to be paid Worker's Compensation benefits for loss of wages if the doctor determines I am still unable to work.

\_\_\_\_\_  
Signature of Injured Employee

\_\_\_\_\_  
Date

If mark is used, two witnesses are required:

1. \_\_\_\_\_

2. \_\_\_\_\_