KENNESAW STATE UNIVERSITY
HUMAN RESOURCES

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 your HR Generalist.**

Injured employee (To be completed by each injured employee)

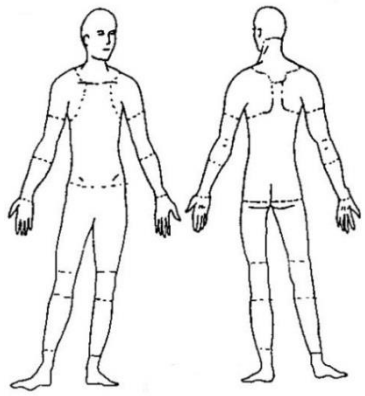
First Name		Last Name			
Employee ID #		Sex	☐ Male ☐ Female	Age	
Home address:				Tel #	
City		State		Zip Code	
Job Title		Department			
Supervisor Name				Supervisor Tel #	

Employment Type	**Employment Category**	**Length of Employment**
☐ Faculty ☐ Staff ☐ Student	☐ Regular full time ☐ Regular part time ☐ Temporary	☐ 1-6 mos. ☐ 6 mos. – 1 yr. ☐ 1 yr. – 5 yrs. ☐ more 5 yrs

Describe the incident

Date of Incident		Time of the incident		Shift	❑ 1st ❑ 2nd ❑ 3rd
Location of the Incident (Address)		Specific Location of the incident (e.g office, mechanical room, shop)			
Did the incident involve property damage?	☐ Yes ☐ No	Was a motor vehicle involved in this incident?		☐ Yes ☐ No	

Affected body Part:



☐ Head/face
☐ Eye
☐ Neck/shoulder
☐ Arms/elbow
☐ Wrist/Head
☐ Right Hand
☐ Left Hand
☐ Fingers
☐ Chest/lower trunk
☐ Rib
☐ Hip
☐ Back
☐ Leg/knee
☐ Foot/ankle
☐ Toes
☐ Other _____

Do you require medical attention	☐ Yes ☐ No ☐ Not sure
Name of your treating physician	
Contact information of your physician	

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

What would your recommend to prevent this accident from recurring:			
Have you reported the incident to your supervisor?	☐ Yes ☐ 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)			
Signatures			
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._____

Reset Form