FLORIDA A&M UNIVERSITY FIRST REPORT OF INJURY AND ILLNESS FORM

Section 1
To Be Completed by Employee

For assistance in reporting a workers' compensation illness or injury, please contact the Office of Human Resources –Workers' Compensation Section at (850) 599-3611. It is mandatory that you report all deaths to the Office of Human Resources. If it is impossible to do so because of the time of the day, or because of the calendar, then the immediate supervisor must report the death within 24 hours to the State of Florida at 1-800-219-8953.

Employee Demographic Information	
Name: (First, Middle Initial, Last)	**Employee's Identification Number:**
Date of Birth:	**Gender: Male ☐ Female ☐**
Street Address:	**City:**
State:	**Zip Code:**
Employee Contact Information	
Cell/Home Phone Number:	**E-mail Address:**
Employee Job Information	
Employee's Position Title:	**Working Department:**
Employee's Work Number:	
Injury Information	
Injury Location - Campus Building Name or if off campus, please provide the injury location:	
Date of injury:	**Time of Injury:**
Time Employee Began Work on Date of injury:	**AM ☐ or PM ☐**

What were you doing immediately before the injury occurred (attached additional sheets, if necessary)?

What Happened (attached additional sheets, if necessary)?

Please go to the next page

What was the resulting injury or illness?

What object or substance directly harmed you?

What body parts were impacted from the injury or illness?

Do you Desire Medical Treatment? Yes ☐ or No ☐

If yes, the University's Manage Care Provider - AmeriSys must be contacted prior to attaining medical treatment for non-lift-threatening injuries/illnesses. ***Please Contact AmeriSys at 1-800-455-2079. Please use Location Code: 0102.***

Any person who knowingly and with intent to injure, defraud, or deceive any employer or insurance company, or a self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.

Employee's Signature: _____ Date: _____

Section 2
To Be Completed By Supervisor

I agree with the description of this incident or illness. Yes ☐ or No ☐
If no, please list reasons (attached additional sheets, if necessary):

Did the employee knowingly refuse to use a safety appliance or have prior knowledge of and fail to observe a safety standard promoted by the department? Yes ☐ or No ☐

This incident requires further investigation? Yes ☐ or No ☐

Please provide a description of the accident (attached additional sheets, if necessary).

Supervisor Signature: _____ Date: _____

Print Supervisor's Name: _____ Phone Number: _____

Supervisor's E-mail address: _____

This Report must be forwarded to Office of Human Resources, 211 Foote-Hilyer Administration Center, Tallahassee, Florida 32307, within 24 hours of reporting the injury or illness.