

Name (Last, First, MI)			SSN		DOB (M/D/Y)		Sex		Marital Status		
Address (include zip)							Phone #				
Work Location/Department				Work Phone			Name of Supervisor			Date of Hire	
Job Title				Empl ID		Classification			FT or PT?		
Date of Injury		Time of incident	Start Time	Date Injury Reported		Time Reported		To Whom Was Injury Reported?			
Activity Engaged in at the Time of Injury						Usual Job Duty?		Location Where Incident Took Place			
Witnesses (Include name, title, and how witnessed)											
How Did the Injury Occur? Describe Sequence of Events and Any Objects or Substances Which May Have Contributed											
Type of Injury and Body Parts Affected								Treatment Received			
Was Treatment at Concentra?			Name, Address / Phone Number of Initial Treatment Facility (if not Concentra)								
Did You Treat Anywhere Else?			If Yes, Where?								
Dates Missed From Work			Does Injury Require Follow Up or Continuing Care? If So, What?								
Have You Ever Injured This Body Part Previously? If Yes, When/How?											
How Can This Type of Injury or Incident Be Prevented in the Future?											
Any Other Relevant Information?											
I attest the above information is true and accurate to the best of my Knowledge. I understand and acknowledge that I may be subject to post-accident or incident drug and/or alcohol testing.											
Employee Signature (Do Not Type Name):								Date:			

Submit to the Office of Human Resources (OHR) within 24 hours of the report of an injury.
 Fax 410-704-6320, email leavebenefits@towson.edu.
 If you have any questions, please call the OHR at 410-704-2162.