SISCO RCM&D SELF-INSURED SERVICES COMPANY, INC.

UCIC
EMPLOYEE INJURY REPORT
FAX: 800-706-9344 / PHONE: 800-641-6330

*Date of Injury (day xx/xx/xx) *Time of Injury

*Work Schedule on Date of Injury

*Employer

*Employee Name First MI Last

*Employee Social Security Number

*Employee Date of Birth

*Home Address

*City, State, Zip Code

County

Home Phone

Work Phone

Fax and/or E-mail Address (optional)

*Job Title

Employee:
☐ *Male ☐ Single
☐ *Female ☐ Married

*State in which Employee was Hired

*Department

Number of Dependents:

Status (Part-time, full-time, student, IC, Seasonal)

Hourly/Salary Wage, if known *Date Hired

Supervisor

Normal Work Schedule

Work Location/Department (as defined by UCIC)

*What was Employee doing when incident occurred?

*What Happened?

*What was the Injury or Illness?

*What Object or Substance if any, directly harmed the employee?

Witness Name and Phone NUmber:

*Fatal Injury? ☐ Yes ☐ No (If Fatal) *List Date of Death

Date of Disability (First day missed work)

Return to Work Date

Full Pay for Date of Injury? ☐ Yes ☐ No

Was Safety Equipment Provided? ☐ Yes ☐ No

Was Safety Equipment Used? ☐ Yes ☐ No

*NATURE OF INJURY

- ☐ Abrasion
- ☐ Amputation
- ☐ Bruise
- ☐ Burn Chemical
- ☐ Burn Thermal
- ☐ Carpal Tunnel
- ☐ Contusion
- ☐ Cut / Laceration
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Electrical Shock
- ☐ Eye Injury
- ☐ Fracture
- ☐ Hernia
- ☐ Infection
- ☐ Infection
- ☐ Irritation Joint or Muscle
- ☐ Other:
- ☐ Puncture Wound
- ☐ Sprain / Strain

*BODY PART

- ☐ Abdomen
- ☐ Ankle L ☐ R ☐
- ☐ Arm L ☐ R ☐
- ☐ Back Upper ☐ Middle ☐ Lower ☐
- ☐ Chest
- ☐ Elbow L ☐ R ☐
- ☐ Finger L ☐ R ☐
- ☐ Foot L ☐ R ☐
- ☐ Forearm L ☐ R ☐
- ☐ Groin
- ☐ Hand L ☐ R ☐
- ☐ Other: _____
- ☐ Head / Face
- ☐ Hip L ☐ R ☐
- ☐ Knee L ☐ R ☐
- ☐ Leg L ☐ R ☐
- ☐ Multiple: _____
- ☐ Neck L ☐ R ☐
- ☐ Shoulder L ☐ R ☐
- ☐ Thigh L ☐ R ☐
- ☐ Thumb L ☐ R ☐
- ☐ Toe(s) L ☐ R ☐

TREATMENT

- ☐ No Medical Treatment
- ☐ Minor by Employee
- ☐ Clinic / Hospital
- ☐ Panel Physician
- ☐ Employee Physician
- ☐ Emergency Care*
- ☐ Hospitalized more than 24 hours*

NAME OF PHYSICIAN/MEDICAL CENTER, ETC.

*Name of Physician/Facility or other medical professional providing care

*Address

*City *State *Zip Code *Phone/Fax Number

REPORT OF INJURY

Date and Time Employer Notified

To Whom

*Name and title of Person Completing Report

*Phone Number/Fax Number

*Date Report Completed

Injured Employee Signature

Date

Equivalent information asked on OSHA forms *(complete where applicable)