UCP of Maine
700 Mt. Hope Ave., Suite 320
Bangor, Maine 04401
207-941-2952 Phone
207-941-2955 Fax

OCCUPATIONAL INJURY REPORT

DIRECTIONS: *Please complete this form in the event of an injury arising out of or in the course of work and turn it in to your supervisor immediately. All related bills should be submitted to Human Resources. All items on the form must be completed to insure a worker's compensation claim is filed in a timely manner.*

1. Name:
_____
First MI Last

2. Address:
_____
Street Town Zip Code

3. SS Number: _____ Home Phone: _____ Work Phone:
_____

4. Date of Birth: _____ Sex: M or F Weekly Wage:
_____

5. Job Title: _____ Date Hired:
_____

6. Do you work for another employer? YES or NO Name and address of other employer (if any):
_____
_____
_____

7. Date: ___/___/___ and time __:__ AM or PM (circle one) of injury

8. Describe your injury.
   A. What body part(s) were injured?
_____
   B. Describe your pain:
_____
   C. What does your injury look like? (If visible)
_____
   D. Other comments about your injury: _____
_____
_____

9. What did you do immediately following your injury? _____
_____
_____

10. Who was present or on duty when you were injured? _____

11. Did the injury occur on our premises? YES or NO

12. Where did the injury occur? (Be specific, location, room, address) _____
_____
_____
_____
_____

13. **Describe the event** which resulted in the injury. **Give full details** on **ALL** factors that led or contributed to the injury. (Attach I/A Report, if applicable).
_____
_____
_____
_____
_____

14. Name the object (i.e. fist, chair, cup) which directly brought on injury:_____
_____
_____
_____
_____
_____

15. What activities do you do at work, that cause you pain from this injury? _____
_____
_____
_____
_____

16. What activities do you do at home or in the community, that cause you pain from this injury?
_____
_____
_____
_____

17. Describe what steps should be taken to prevent this injury from occurring in the future:
_____
_____
_____
_____

18. Did you receive medical attention? YES or NO

Check all that apply:

___ Treated self with first aid ___ Emergency Room ___ Healthworks ___

Other

_____

19. Date your UCP supervisor was notified: _____

Time your supervisor was notified: _____

Name of supervisor notified: _____

20. Time your workday began: _____ AM or PM Date your work day began: _____ What time did you leave shift on the day of your injury? _____ AM or PM

What date did your shift end? _____

21. Did you lose one or more days of work? YES or NO

A. If yes, give the date of the first full day you lost time from scheduled work:

_____

_____

B. If yes, list any/all dates that you lost time from scheduled work:

_____

_____

C. If yes, date you returned to work: _____ at _____ AM or PM.

EMPLOYEE SIGNATURE/DATE:

_____

SUPERVISOR SIGNATURE/DATE:

_____

DATE RECEIVED BY HUMAN RESOURCES:

_____

CLAIM NUMBER (if any): _____ (MEMIC) _____ (Worker's Comp)

SUPERVISOR'S FOLLOW UP/PREVENTIVE SAFETY PRECAUTIONS TAKEN

_____

_____

_____

_____

Dev. 4/9/07 MRW