MILLERSVILLE UNIVERSITY
EMPLOYEE'S REPORT OF INJURY

Name _____ Perner # _____

Address _____
Street City State Zip

Home or Cell number _____ Occupation _____

Department _____

Birthdate _____ Married ☐ Yes ☐ No Number of Dependents _____

List Any Other Employment _____

* *

Date of Injury _____ Time _____ AM ☐ PM ☐

Date Injury was Reported _____

Who was Injury reported to _____

Describe fully how injury happened: _____

_____

_____

_____

_____

_____

Injury Witnessed by: _____

What part(s) of your body were injured _____

_____

_____

Did you stop work as a result of your injury _____ When _____

From whom did you receive your first medical treatment _____

Date of first treatment _____