EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

Please complete entire form & return to Human Resources *within 48 hours* {fax 871-7950}.
If you have questions, please call 871-4950

1. Date of Report (today)	2. Date of Injury	Time of Injury ☐ AM ☐ PM	3. Starting Time on Date of Injury ☐ AM ☐ PM	4. If Employee Back to Work, Give Date
5. If Fatal Injury, Give Date of Death	6. Date Supervisor Knew of Injury		7. Date Disability Began	
8. Employer Millersville University			9. Person Making Out This Report **(SUPERVISOR)**	
10. Employer's Street Address PO Box 1002			11. City, State, Zip Code Millersville, PA 17551M 1(i)-0.7 (i)-2.7 (t)8r4.3 (1(**i**)-0)44t	