

**Ames Laboratory / ISU**  
**Supplementary Record of Occupational Injury or Illness**

Case Number \_\_\_\_\_

(To be filled out by employee and supervisor)  
Return completed form to Occupational Medicine (G11 TASF) within two (2) days of the event.

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**Injured/Ill Employee**

Name \_\_\_\_\_ Ames Lab Employee No. \_\_\_\_\_  
(First, Middle, Last Name)

Home Address \_\_\_\_\_  
Number and Street City State ZIP

Age \_\_\_\_\_ Gender:  Male  Female Supervisor \_\_\_\_\_

Job Title \_\_\_\_\_ Department \_\_\_\_\_

Job Classification (Circle One): P&S, Merit, Graduate, Post Doc, Faculty, Associate or Casual Hourly

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**Event**

Occurred at (Room/Building, Address) \_\_\_\_\_

What was the employee doing? \_\_\_\_\_

How did the event occur? (Describe completely) \_\_\_\_\_

Describe the injury or illness in detail (e.g. "laceration requiring stitches", "respiratory irritation", "dermatitis")

What caused the injury/illness: (e.g. "sharp metal edge of shelf", "inhaled vapor from acid", "skin contact with chemical solution")

Date/Time of Event or Diagnosis of injury/illness \_\_\_\_\_

Name of Treating Physician/Health Care Provider \_\_\_\_\_

Physician's/Health Care Provider's Address \_\_\_\_\_  
Number/Street City State ZIP

If hospitalized, name/address of hospital \_\_\_\_\_

Name of Admitting Physician \_\_\_\_\_

(Continued on other side)

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Corrective Actions (Steps taken to prevent recurrence, correct the conditions) \_\_\_\_\_

What Corrective Action steps remain to be done? \_\_\_\_\_

Work Restrictions prescribed by Physician/Health Care Provider \_\_\_\_\_

Lost Work Days (Days away from work after the day of the event, including week-ends and holidays) \_\_\_\_\_

Restricted Work Days (Days in which adjustments needed to be made in tasks or assignments) \_\_\_\_\_

Prescribed Work Restrictions had an impact on my ability to work **YES / NO**  
(circle one)

If YES, please comment: \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Prescribed Work Restrictions had an impact on the assigned work for the employee **YES / NO.**  
(Circle one)

If YES, please comment: \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_

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**ESH&A Review of Record**

Manager/Group Leader of injured to meet with a member of Executive Council, who in turn will discuss with remaining council members:  Yes  No Comments \_\_\_\_\_

Signature of Reviewing Official \_\_\_\_\_ Date \_\_\_\_\_

**Manager, Environment, Safety, Health and Assurance**