



Incident #

FIRST REPORT OF WORK-RELATED ACCIDENT

INSTRUCTIONS: This report must be completed and delivered to the Office of Human Resources within 24 hours of any accident. All work related accidents must be reported.

Serious Injury:

- 1. Obtain immediate medical treatment; transport employee to Cooley Dickinson Emergency Room (or call ambulance if necessary and Public Safety at x800).
2. Contact the Office of Human Resources to report accident (x2275) as soon as possible.
3. Complete the "First Report of Work-Related Accident" form in full and deliver it to the Office of Human Resources within 24 hours.

Minor Injury:

- 1. Administer minor first aid.
2. Contact the Office of Human Resources (x2275) to arrange for medical treatment / examination if needed.
3. Complete the "First Report of Work-Related Accident" form in full and deliver it to the Office of Human Resources within 24 hours.

SECTION I - Incident Report (to be completed by employee)

Date of Incident: Time of Incident: a.m. pm.

Brief description of Injury (ex sprained wrist)

Exact Location of Where Injury Occurred:

NATURE OF INJURY:

- Sprain
Strain
Contusion / Bruise
Laceration / Cut
Abrasion / Scrape
Burn
Fracture
Electrocution
Other (describe)

INJURED BODY PART:

- Arm, Leg, Hand(s), Wrist, Ankle, Back, Neck, Face, Head, Other (describe)
Right, Left
Right, Left
Right, Left
Right, Left
Lower, Upper

EE's Description of How the Injury Occurred:

EE's Recommendation of How to Prevent Recurrence of This Accident:

Name of Supervisor: Date Supr Notified:

Employee's Signature: Date:

SECTION II - Employee Information & Medical Release (to be completed by employee)

Name: _____ Employee ID#: _____
Home Adrs: _____ Marital Status: Single Married
_____ Gender: Male Female
Home Phone: _____ Date of Birth: _____
Date of Hire: _____ Position: _____ Department: _____

"I hereby authorize Smith College and ISCC or TPA (or any of their representatives) to be furnished any information and facts regarding this injury, including reports and records, diagnosis results, treatment and prognosis, x-rays, disability estimates and recommendations for further treatment." A copy of this authorization shall be effective and valid

Employee Signature: _____ Date: _____

SECTION III - Supervisor Report (to be completed by supervisor)

Describe the Employee's Injury: _____

Medical Treatment Received - Employee's need to submit hospital discharge paperwork or all physician's treatment documentation to The Office of Human Resources.

Cooley Dickinson Hospital Occupational Health / Own Physician First Aid None
Was Any Work Time Lost: Yes No Expected Lost Work Time: _____
Date Expected to Return to Work: _____

DESCRIPTION OF THE INCIDENT:

What was the employee doing when injured? _____
What caused the injury _____
Who witnessed the injury? _____
Did the injury result from unsafe work conditions or equipment? Yes No
Would safety equipment (gloves, glasses, shoes, etc.) have prevented/lessened the Injury? Yes No
If yes, explain _____
What actions can be taken to prevent recurrence? _____

Signature of Supervisor: _____ Date: _____

Signature of Department Head/Chair: _____ Date: _____