



FIRST REPORT OF WORK-RELATED ACCIDENT

INSTRUCTIONS: All work related accidents must be reported to the Office of Human Resources (x2267) as soon as possible. Complete this form and send it to the Office of Human Resources within 24 hours of any accident. If there is a serious injury, obtain immediate medical treatment; transport worker to Cooley Dickinson Emergency Room (or call ambulance if necessary and Public Safety at x800).

SECTION I - Incident Report (to be completed by worker):

Time work shift began: _____ AM PM

Date of injury: _____ Time of injury: _____ AM PM

Name of Supervisor (print): _____ Date Supervisor Notified: _____

Exact location of where the incident occurred (ex. King/Scales kitchen): _____

INJURED BODY PART (incident type):

NATURE OF INJURY (medical condition):

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

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

Brief description of injury (ex. sprained wrist): _____

Worker's description of how the injury occurred (incident comments): _____

Worker's recommendation of how to prevent recurrent of this incident: _____

SECTION II - Worker Information & Medical Release (to be completed by worker)

- Employee, Student Worker, Volunteer, Agency Temp, Summer Program

Smith ID#: _____ Name: _____

Home Address: _____

Home Phone Number: _____ Date of Birth: _____

"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.

Workers Signature: _____ Date: _____

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

Medical treatment received (worker must submit all medical documentation to the Office of Human Resources):

Emergency Room AEIOU/Occupational & Urgent Health Care First Aid None

Primary Care Physician ~ Name/Phone #: _____

Was any work time lost? Yes No If yes, expected lost work time? _____

Description of incident (print clearly):

Describe the worker's injury (ex. Chemical burn, left hand): _____

What happened (ex. missed last step, fell)? _____

What object or substance directly harmed the worker (ex. concrete floor)? _____

Who witnessed the incident? _____

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 the recurrence? _____

Signature of Worker: _____ **Date:** _____

Signature of Supervisor: _____ **Date:** _____

Signature Dept Head/Chair: _____ **Date:** _____

<p>For HR use only:</p> <p>Received by: _____</p> <p>Date Received: _____</p> <p>Case/Incident #: _____</p> <p><input type="checkbox"/> Notice Only</p> <p><input type="checkbox"/> Medical Only</p> <p><input type="checkbox"/> Medical/Lost Time</p> <p><input type="checkbox"/> Form 101</p>
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<p>Workers Compensation Information:</p> <p>Meadowbrook/TPA Associates 10 New England Business Ctr, Suite 303 Andover, MA 01810</p> <p>Contact: Nicole Black Phone: 978-691-2470 x2118 Fax: 978-691-2477</p>
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