

University of New Hampshire Employer's Report of Occupational Injury or Illness

UNIVERSITY POLICY REQUIRES THAT REPORT OF INJURY/OCCUPATIONAL ILLNESS BE REPORTED WITHIN 24 HOURS OF OCCURRENCE.

This form must be completed in its entirety and faxed to (862-1222) Human Resources Workers' Compensation Coordinator, 2 Leavitt Lane. Omission of information could result in a delay of benefits.

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA	Employee Name (Print):		Employee's ID #:		
	Address:		Home Phone () Cell Number ()		
	City/State/Zip:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:	
	Department/Location:		Department Work Phone: ()		
	Position Title:		Date of Hire:		
	Supervisor's Name (Print):		Supervisor's Work Phone: ()		
Staff () Hourly () Student Hourly/Work Study ()		() hours per day	() days per week	() total weekly hours	

EMPLOYEE STATEMENT	Specific Injury/Illness/Exposure:		Date of Injury/Illness:		Body Part(s) Affected: <input type="checkbox"/> Left <input type="checkbox"/> Right	
			Time: <input type="checkbox"/> am <input type="checkbox"/> pm			
	Location where injury or illness occurred:				Any Loss Time?	
	What equipment, materials or chemicals caused the injury/illness? :				Who witnessed this injury?	
	Explain in detail how the injury occurred. Include specific activities/tasks performed at the time.					
	Medical Treatment provided by: <input type="checkbox"/> First Aid, no medical care needed <input type="checkbox"/> Seacoast Redi-Care <input type="checkbox"/> Occupational Health Services/Pease Trade Port <input type="checkbox"/> UNH Health Services <input type="checkbox"/> Private Physician (Name & Phone#) _____ Hospital ER (Place) _____ <input type="checkbox"/> Other: (Provider Name & Phone#) _____					
Employee Signature: _____				Today's Date: _____		

EMPLOYER'S INVESTIGATION AND STATEMENT (EMPLOYER COMPLETES):

EMPLOYER	After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed:	
	What was the injury, illness or exposure?	

INITIAL CAUSE	CONTRIBUTING FACTORS AND ACTIVITIES	PREVENTIVE ACTIONS
<input type="checkbox"/> Struck by or against object (indicate) <input type="checkbox"/> Caught in/under/ between <input type="checkbox"/> Fall / Slip / Trip <input type="checkbox"/> Material handling or lifting <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Body fluid exposure: <input type="checkbox"/> Needle stick <input type="checkbox"/> Sharps <input type="checkbox"/> Animal bite <input type="checkbox"/> Other, Explain _____ _____ _____ _____	Equipment <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment or material used for job Personal protective equipment <input type="checkbox"/> Not worn <input type="checkbox"/> Not readily available <input type="checkbox"/> Not adequate for the task <input type="checkbox"/> Personal protective equipment failure Training/Experience <input type="checkbox"/> Lack of training <input type="checkbox"/> Safety training provided, not followed <input type="checkbox"/> New task for employee or lack of experience Work Area <input type="checkbox"/> Work area set up improperly <input type="checkbox"/> Inadequate lighting or noise issues <input type="checkbox"/> Housekeeping issues <input type="checkbox"/> Environmental factors (rain, wind, temp. etc) Use additional pages as needed	SUPERVISOR WILL: <input type="checkbox"/> Develop/revise safety procedures <input type="checkbox"/> Request ergonomic evaluation assistance <input type="checkbox"/> Order new equipment <input type="checkbox"/> Order new personal protective equipment <input type="checkbox"/> Remove equipment from use and repair/replace <input type="checkbox"/> Schedule preventive maintenance <input type="checkbox"/> Will retrain employee before task is re-assigned <input type="checkbox"/> Perform on-site review of work activity, update job safety analysis <input type="checkbox"/> Reconfigure work area <input type="checkbox"/> Communicate corrective actions to others in job category <input type="checkbox"/> Other _____ Preventive actions will be completed by: Name _____ Expected date of completion _____

SUPERVISOR OR MANAGER COMPLETING THIS FORM			Date of Investigation:
Print Name: _____	Signature: _____	Phone Number: _____	