

## 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:**

<b>EMPLOYEE DATA</b>	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

<b>EMPLOYEE STATEMENT</b>	Specific Injury/Illness/Exposure:			
	Location where injury or illness occurred:			
	<b>Date of Injury:</b>		<b>Body Part (s) Affected:</b>	
			<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> am <input type="checkbox"/> pm	
	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):**

<b>EMPLOYER</b>	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: ___ Needle stick ___ Sharps <input type="checkbox"/> Animal bite <input type="checkbox"/> Other, Explain _____ _____ _____ _____	<b>Equipment</b> <input type="checkbox"/> Equipment failure <input type="checkbox"/> Equipment unavailable <input type="checkbox"/> Improper equipment or material used for job <b>Personal protective equipment</b> <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 <b>Training/Experience</b> <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 <b>Work Area</b> <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)	<input type="checkbox"/> Ventilation issues <input type="checkbox"/> Ergonomic factors <b>Employee</b> <input type="checkbox"/> Physically not able to do work <input type="checkbox"/> Employee fatigue <input type="checkbox"/> Unbalanced or poor position or motion <input type="checkbox"/> Incorrect procedures used for task <input type="checkbox"/> Other unsafe practice <b>Assistance</b> <input type="checkbox"/> Difficult to perform task without help <input type="checkbox"/> Safety features or devices not readily available <input type="checkbox"/> Assistive devices not used <input type="checkbox"/> <b>Lack of policy/procedure</b> <input type="checkbox"/> <b>Animal</b> (explain below) <input type="checkbox"/> <b>Other</b> (explain) _____ _____ _____ _____ <b>Use additional pages as needed</b>
		<b>SUPERVISOR WILL:</b> <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 _____ _____ <b>Preventive actions will be completed by:</b> Name _____ Expected date of completion _____

<b>SUPERVISOR OR MANAGER COMPLETING THIS FORM</b> Print Name: _____	Signature: _____	Phone Number: _____	Date of Investigation: _____
--	------------------	---------------------	------------------------------