

EMPLOYEE'S REPORT OF ACCIDENT

(For all employees. Please print and write with a pen)

ALL OF THIS INFORMATION IS VERY IMPORTANT TO PROCESS YOUR WORK INJURY.

If this is a significant injury, call Human Resource Office immediately at **X53675**

Employee Information:

Personal ID# _____
First Name _____
Last Name _____
Social Security # _____
Date of Birth _____ Age _____
Gender: Male _____ Female _____
Marital Status Married _____ Single _____
Number of Dependents _____
Mailing Address _____
City/State/Zip _____
Home Phone _____

Work Information

Job Title _____
Department _____
Supervisor _____
Department _____
Date of Hire _____
Hrs. work/day _____ week _____

Injury Information

Date of Injury _____ Time _____am/pm
Date injury reported to supervisor _____
Lost time from work Yes _____ No _____
If yes, give dates you were off work _____
Give return to work date _____
Was the required safety gear used (e.g., goggles, gloves, shoes, etc.)? Yes _____ No _____

Description (Please be specific & detailed)

Location of injury (area in which injury occurred, e.g., Seaside's by cashier.)

What was employee doing when injured?

What was the direct cause of the injury?

Check specific body part injured:

R arm _____ R hand _____ R shldr _____ R eye _____
L arm _____ L hand _____ L shldr _____ L eye _____
R leg _____ R foot _____ R knee _____ Head _____
L leg _____ L foot _____ L knee _____ Torso _____
Back _____
Other: _____

Type of Injury:

Cut _____ Burn _____ Slip/Fall _____ Sprain/strain _____

Did you see a doctor for this injury?

Yes _____ No _____

If yes, when? _____

Name of attending physician _____

Did injury require sutures or other medical attention?

Yes _____ No _____

Medical Information Authorization

I hereby authorize the release of complete medical records and X-rays regarding said injury above that are in the possession of the attending physician/hospital concerning any and all medical history of treatment rendered by the attending physician/hospital, and any other information specifically requested, to be sent to the Brigham Young University Hawaii Human Resource office, Box 1969, 55-220 Kulanui St., Laie, HI 96762. A photocopy of this authorization shall be accepted as granting the same authority as the signed original document.

Employee's Signature _____ Date _____ Witness Signature _____
If other than Supervisor

_____ Supervisor's Signature

_____ Supervisor's extension _____ Risk Management Signature

All work related injuries MUST be reported to the Human Resource Office within 24 HOURS.

If you have any questions regarding this report, please contact Human Resources at X53675.

Make a copy of this report for your department and submit the original to Human Resources.

FACTS OF THE ACCIDENT
(Supervisor's Report of Accident)

Employee Information:

Employee Name: _____

Job being performed at the time of the accident: _____

Immediate Supervisor's name (Please Print): _____

Location of accident: _____

Date and time of accident: _____

Witnesses of accident: _____

Precise Detail of accident:

What could have been done to prevent the accident?

Was the accident investigated? If yes, by whom? Yes No (Please submit a copy of the report)

Has the employee had a similar injury? Yes No

If yes, give a date. _____

Was employee taken to an emergency room? Yes No

Has the employee returned to work full duty? Yes No

Have you received a doctor's note returning the employee to full-duty? Yes No

What corrective measures, if any, have been made? _____

Note: It is very important that if you were seen by a doctor that you have a doctor's note releasing you to work on full or light duty. Supervisor, any injured employee who has been seen by a doctor for a work-related injury may not return to work without a return to work slip. It is important that this work slip is turned into the Human Resource office. Contact the Human Resource office for further information at X53675.