SMITH COLLEGE

FIRST REPORT OF WORK-RELATED ACCIDENT

INSTRUCTIONS: All work related accidents must be reported to the Office of Human Resources (x2268) 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):

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

NATURE OF INJURY (medical condition):

- ☐ 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. Smith College provides transitional duty work will work with you to accommodate your injury. If seeking medical attention, you are required to provide medical documentation to the Office of Human Resources after every appointment.

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 ☐ The Work Connection/Holyoke Medical Center ☐ 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:** _____

Supervisor Signature: _____ **Date:** _____

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

Signature Human Resources: _____ **Date:** _____

For HR use only:

Date Received: _____

Case/Incident #: _____

__ Notice Only
__ Medical Only
__ Medical/Lost Time
__ Form 101