Employee's Report of Work-Related Injury
University of Maryland, College Park

To be completed <u>immediately</u> after the accident or initial treatment and submitted to your supervisor

Employee Name: _____ UID: _____ Male ☐
(First) (Last) Female ☐

Date of Birth: _____ Marital Status: _____ No. of Dependent Children: _____

Home Address: _____ Phone No._____
Street City Zip Code

Employment Status (check one): Contingent I ☐ Contingent II ☐ Hourly ☐
Faculty ☐ Non-exempt FT/ PT ☐ Exempt FT/PT ☐ Research/Grad Assistant ☐

Job Title: _____ Employment Start Date: _____ Time workday began: _____

Department: _____ Work Phone No. _____Gross wages (biweekly): $_____

Date of Accident: _____ Time: _____ Location: _____
Bldg. Area (hall way, office, etc)

Describe in detail how the accident occurred: _____
_____
_____
_____

(describe the work-process you were engaged in, give the purpose of the function or task, describe how the injury occurred, and explain the cause)

Part of body injured: _____ Type of injury: _____
(be specific - example: right middle finger, left ankle, upper back) (example: sprain, burn {degree of burn}, contusion, sutured)

Was medical treatment sought? If so: _____
Name of medical provider Phone Number

No. of days missed from work: _____ Return to work date (as stated by physician): _____
Type of leave used: _____ No. of days worked with restrictions: _____

Name of witness (es): _____ Phone No. _____

Was safety equipment provided? Yes _____ No_____ Was safety equipment used? Yes _____ No_____

Supervisor's Name: _____ Phone No._____

Signature of employee: _____ Date: _____

Questions? Call 301-405-5466 see
also http://www.essr.umd.edu

03/2015

Employee Instructions for Work-Related Injury or Illness

The following information is provided to guide the employee who is injured while at work. It is important that these instructions be followed in order to receive all available benefits.

If possible, provide a verbal description of the accident to your supervisor, immediately after the accident.

Medical Treatment:

***Injured while on campus*:**
If you are injured while working on campus and need medical attention, it is recommended that you go to the Health Center. The Health Center will provide you with all the necessary forms to report the accident. Provide your immediate supervisor with the Supervisor's Report of Work Related Injury form for completion and your completed Employee's Report of Work Related Injury form.

***Injured while off campus*:**
If you are injured while off campus and go to an emergency room or see your private physician, the accident report forms are available on the ESSR web site:

> http://www.essr.umd.edu/ - click on Risk Management/Workers' Compensation and then click into the desired forms format.

Immediately following your initial treatment complete the accident report form and forward it to your supervisor**.**

IMPORTANT: Any medical treatment other than emergency visits, initial treatments, or routine office visits must be pre-authorized. Your medical provider will ask you for a "claim number" and insurance information. Once you have completed and submitted the accident report form, call the Workers' Compensation office @ (301) 405-5466 to obtain this number and information.

The Injured Workers' Insurance Fund (IWIF) is the workers' compensation insurance carrier for University employees. The IWIF adjuster may call you to investigate the incident. Provide as many details about the accident as you can. It will aid the adjuster in determining whether your injury is compensable under the Maryland Workers' Compensation Law.

- ***Note: If you do not complete and submit the injury report, the Health Center will bill for services rendered.***
- ***You must provide your supervisor with a note from your doctor for any time off due to a job injury disability - regardless of what type of leave you are using.***

Supervisor's Report of Work-Related Injury
University of Maryland, College Park

To be completed by the supervisor or higher authority and submitted with all other reports to Workers' Compensation, Environmental Safety, Seneca Bldg. 4716 Pontiac St. within 24 hours

(Claim) IWIF # _____ (to be completed by DES/WC)

Name of injured employee: _____

Date of accident: _____ Date Employer/Supervisor was notified: _____

Location of accident: _____ Time of accident: _____
Bldg. Area (hallway, office, parking lot, etc.)

Describe in detail how the accident occurred:

_____

_____

_____

(**describe the work-process the employee was engaged in, give the purpose of the function or task, describe how the injury occurred, and explain the cause)**

Part of body injured: _____ Type of Injury: _____
(please be specific - example: right middle finger, left ankle, upper back) (example: sprain, burn {degree of burn}, contusion, sutures)

Return to work date (as stated by the physician): _____ No. of days missed from work: _____

Type of leave used: _____ No. of days worked with restrictions: _____

Witnesses to Injury:

Name	Job Title	Phone No.

Do you agree with the employee's description of the accident: Yes_____ No _____If no, explain:

_____

_____

Was safety equipment provided? Yes ___ No___ Was safety equipment used? Yes ___ No___
If no, explain: _____

Recommendation on how to prevent this accident from recurring:

_____

_____

Name of supervisor/department: _____ Work Phone No: _____
Signature of supervisor: _____ Date: _____

Questions? Call 301-405-5466 see
also http://www.essr.umd.edu

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Supervisor's Instructions for Reporting a Work-Related Injury

Get as many details as possible about the incident from the employee and witness (es)

Collect the completed *Employee's Report of Work-Related Injury Form* and *Accident Witness Statement.* Complete the *Supervisor's Report of Work-Related Injury Form* and return all forms within 24 hours to:

Workers' Compensation
Department of Environmental Safety
Seneca Bldg., 4716 Pontiac St. Suite 0103

Report the number of days lost from work and/or the number of days employee is working with restrictions. If the information is not available at the time of completing the report, call the Workers' Compensation Office (301) 405-5466 when the employee returns to work or is no longer working with restrictions.

When an employee is absent due to a job injury, the supervisor must require medical documentation for this disability. If long term, disability notes are required every two weeks. This medical documentation should contain:

a diagnosis
current medical management
restrictions
a return to work date

If the employee is returned to work in a modified duty capacity, the supervisor should make every effort to accommodate the restrictions. University policy states that an employee is eligible for accident leave immediately for up to 30 days unless otherwise notified. Only employees in "permanent employment" status are eligible for accident leave.

Any questions call (301) 405-5466.

Accident Witness Statement
University of Maryland, College Park

(to be completed <u>within 24 hours</u> of the accident)

Name of injured employee: _____

Department: _____ Job Title: _____

Location of accident: _____
Bldg. Area (hallway, office, parking lot)

Date of accident: _____ Time of accident: _____

Did you witness the accident? Yes _____ No_____

Describe in detail how the accident occurred:

_____

_____

_____

_____

(describe what employee was doing, how the accident occurred, and what caused it)

Part of body injured (please be specific - example: right middle finger, left ankle, upper back): _____

Was safety equipment provided? Yes _____ No _____ Was safety equipment used? Yes _____ No _____
If no, explain: _____

_____

Recommendation on how to prevent this accident from recurring: _____

_____

Name of witness: _____ Work Phone: _____

Signature of witness: _____ Date: _____

Questions? Call 301-405-5466
see also http://www.essr.umd.edu/

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