**First Report of Injury/Incident**

All injuries to students, employees, or visitors, and all non-injury incidents must be reported **by end of shift** to the Human Resources Office 906-635-2626 or Public Safety 906-635-2100. It is the responsibility of the individual to report any injury or non-injury incident to his or her supervisor immediately. If more than one person was involved in an incident, each person must fill out a separate report. In preparing the report, avoid non-specifics or generalities. Information provided may help other departments in preventing similar incidents.

**Name of Person Involved** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Univ ID No** A\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

**Local Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:** **[ ]  Male** **[ ]  Female** *(check one)*

**Status:** **[ ]  Employee** **[ ]  Student Employee** **[ ]  Non-Working Student** **[ ]  Visitor** *(check one)*

**If an Employee/Student Employee**

**Date of Incident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_** **[ ]  AM** **[ ]  PM** *(check one)*

**Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Shift Began \_\_\_\_\_\_\_\_\_\_\_\_\_\_** **[ ]  AM** **[ ]  PM** *(check one)*

**Time and date stopped work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time and date of anticipated return to work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specific Location of Incident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name(s) of Witnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of injury** *(specify exact part of body) circle one* ***right or left*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of Injury** *(sprain, burn, etc.)* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What was he or she doing at the time of the accident?** *(Include tools, machines, objects, materials being used)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did the injury and/or incident occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(attach additional documentation if necessary)*

 ***I understand I may be evaluated by a Medical Professional, however I decline treatment at this time. I understand***

 ***I have the option to request Medical Evaluation within 48 hours of incident.***

 **Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did injured receive first aid?** **[ ]  Yes** **[ ]  No Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Room Visit** **[ ]  Yes** **[ ]  No**

**Treated by healthcare provider?** **[ ]  Yes** **[ ]  No Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hospital** *(if any)* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital overnight inpatient?** **[ ]  Yes** **[ ]  No X-rays taken?** **[ ]  Yes** **[ ]  No**

**Statement by person involved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(attach additional documentation if necessary)*

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Signature of Involved Person Date Signature of Department Head Date**

**Distribution:** Original to Safety and Risk Office, Reporting Department Retains a Copy

**Injury/Incident Notification Procedures**

If an employee is seriously injured, call Public Safety 906-635-2100 or **call 911** and obtain professional medical assistance immediately. If there is ever any doubt to the seriousness of an injury, always err on the side of caution and call 911. If an injured person requests that 911 be called, do so without hesitation.

1. Render first aid.
2. An employee shall **report** any work-related injury, no matter how slight, to their **s**upervisor, immediately. An employee First Report of Injury/Incident form will be utilized for reporting purposes. This form is distributed to all departments and is available at https://www.lssu.edu/human-resources/employee-forms/. A supervisor receiving a report or notice of an injury from the employee shall promptly assist employee with completion of Incident Report and report the claim to the Safety and Risk Specialist or designee. An injury may be reported by a supervisor on behalf of the employee.
3. Employees must report injuries to the TeleCompCare Nurse Triage line at 866-323-4227 and will be referred to the preferred occupational provider if deemed medically necessary. Health Care Providers must be informed if the incident is **work-related** at the time of the medical registration. If you seek unauthorized treatment, you may be responsible for associated costs.
4. If the employee does not report the injury by end of shift to their supervisor per policy, disciplinary action may occur.
5. The Director of Public Safety/Human Resources will review the required information on the First Report of Injury/Incident for accuracy involving the incident and for Safety concerns.
6. All original documentation given to the employee by the treating health care provider must be returned to the Director of Public Safety/Human Resources or designee within the next business day.

These medical forms provide timely information regarding employee compensation, injury information status, and MIOSHA recording requirements. Claims may be denied due to insufficient information and delayed injury notification.

1. Employees must follow all health care provider documented restrictions and follow up appointments**.** All follow up appointments must be made with thepreferred Provider,referred to a specialist. Employees must submit documentation to the Director of Public Safety/Human Resources after each follow up appointment.
2. The Director of Public Safety/Human Resources may assign accommodated work for employees returning from their medical evaluation with a documented need for accommodation LSSU Fit for Duty Certification form.
3. Prior to returning to regular work the employee must provide the Director of Public Safety/Human Resources with the health care provider’s documentation of return to work with full capabilities or a listing of specific capabilities based on the LSSU Fit for Duty Certification form.