



FIRST REPORT OF WORK-RELATED ACCIDENT

INSTRUCTIONS: All work-related accidents must be reported to the Human Resources Department within 24 hours of any accident. If there is a serious injury, obtain immediate medical treatment; transport employee to Cooley Dickinson Emergency Room (or call ambulance if necessary and Public Safety at x5555). Please complete ALL questions on the form.

SECTION I - Incident Report (to be completed by employee):

Employee's Name: _____

Position: _____

Department: _____

Date of injury: _____

Time Arrived at Work: _____ AM PM

Time of injury: _____ AM PM

Name of Manager (print): _____ Date Manager Notified: _____

Exact location of where the incident occurred (ex. King/Scales kitchen): _____

Workers Description of Incident: _____

Table with 3 columns: INJURED BODY PART (check all that apply), NATURE OF INJURY (check one), and SOURCE OF INJURY. Lists various body parts, injury types, and sources like Burn, Chemical, Collision, etc.

What were you (employee) doing right before the incident: _____

Describe the facts about the accident in detail: _____

What preventative measures need to be taken: _____

"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.

Employee's Signature: _____

Date: _____

SECTION II - Manager Report (to be completed by manager):

Was medical treatment received: Yes No

If **Yes**, please check box below:

- Emergency Room
- The Work Connection/Holyoke Medical Center
- First Aid
- Primary Care Physician ~ Name/Phone #: _____

Was any work time lost? Yes No If yes, expected lost work time? _____

Description of incident (print clearly):

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? _____

Manager Signature: _____

Date: _____