FIVE COLLEGE CONSORTIUM

FIRST REPORT OF WORK-RELATED ACCIDENT
to be competed by worker

INSTRUCTIONS: All work related accidents must be reported to the FCI Director of Operations as soon as possible. Complete this form and send it to the Director of Operations ***within 24 hours of any accident***. If there is a serious injury, first obtain immediate medical treatment; if needed, transport worker to the emergency department of the nearest hospital (or call ambulance if necessary).

SECTION I - Injured Party Information

Category:

☐ Employee ☐ Student Worker ☐ Volunteer ☐ Other _____

Name: _____

Home Address: _____

Home Phone Number: _____ Primary Work Location (campus & bldg): _____

SECTION II - Injury Report

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 (e.g., Annex 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 (e.g., scraped wrist): _____

Worker's description of how the injury occurred (incident comments): _____

_____

_____

Medical treatment received (worker must submit all medical documentation to the Director of Operations):

☐ Emergency Room ☐ Urgent Care ☐ First Aid ☐ None

☐ Primary Care Physician Name & Phone #: _____

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

SECTION III - Incident Report

Description of incident:

Describe the worker's injury (e.g., chemical burn, left hand): _____

What happened (e.g., missed last step, fell)? _____

_____

What object or substance directly harmed the worker (e.g., 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 recurrence? _____

_____

SECTION IV - Attestation & Medical Release

I attest that the statements provided here are true and correct. I understand that any false statements, falsified documents, or deliberate omission of information could lead to disciplinary or legal action.

I hereby authorize Five Colleges, Incorporated and its workers compensation insurer 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. Five Colleges will work with you to accommodate your injury. If seeking medical attention, you are expected to provide medical documentation of your appointments.

Signature of Worker: _____ **Date:** _____

SECTION V - Acknowledgments

I am aware of this incident and understand that I may provide additional information about the incident or injury.

Supervisor: _____ **Date:** _____

Unit Head: _____ **Date:** _____

Human Resources: _____ **Date:** _____

For FCI use only:

Date Received: _____

Case/Incident #: _____

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