Workers' Compensation Employee Injuries and Illnesses

Instructions for completing this form:

- Only use this form if you do not have a login ID or password for the Cannon Cochran Management Services, Inc (CCMSI) on-line injury/illness reporting system.
- This form is to be completed by the supervisor or designated individual. It is not to be completed by the injured employee.
- When you have completed this form, f**ax it to HR Employee Benefits office at 581-1615** for entry into the CCMSI on-line injury/illness reporting system.

Campus Site Location: *(i.e. UMaine Campus, Cooperative Extension office, Aroostook Farm, etc.)*		Report Type: ☐ Report Only *(no medical charges)* ☐ Claim *(medical charges, etc.)*
Date of Injury/Illness:		Time of Injury/Illness:
Last Name:		Home Address:
First Name:	MI:	
Date of Birth:		
Home Phone:		
Work Phone:		
Marital Status:		Gender:
Employee ID (MaineStreet):	Department Name:	
Supervisor's Name:		Supervisor's Phone:
Supervisor's Title:		Time Employee Begins Work:

Was the employee performing regular duties? ☐ Yes ☐ No

What general activity was the employee engaged in?
(i.e. doing dishes, cutting vegetables, using computer, mopping floors, general office duties, repairing equipment)

Did another person cause this accident? ☐ Yes ☐ No
If yes, who caused this accident?

Is there a reason to doubt the validity of this claim? ☐ Yes ☐ No
If yes, please state the reason:

Is this a reoccurrence of an existing case? ☐ Yes ☐ No
If yes, please provide date of original case:

Healthcare Info: Did a physician or other licensed healthcare professional prescribe days away, restrictions, or medications? ☐ Yes ☐ No

- ☐ Days away from work? If checked; list dates:
- ☐ Work restrictions? If checked; list the restrictions and the dates:
- ☐ Days away from work? If checked; list dates
- ☐ Check if medications were prescribed for this injury.

Did the employee receive a needlestick injury or cut from other sharp object that was contaminated with **another person's** blood or other potentially infectious material?
☐ Yes ☐ No

Was Personal Protective Equipment (PPE) required for the task? *(e.g. safety goggles, safety toed shoes, etc.)* ☐ Yes ☐ No

If yes was selected, please answer the following:

- Was PPE available? *(e.g. did the department have available gloves, goggles, etc. to protect the employee from hazards?)* ☐ Yes ☐ No
- Was PPE used? ☐ Yes ☐ No
- If PPE was required, but not used, please indicate why:

Were safety procedures followed? (e.g., did the employee use the required protective equipment, follow written policies, follow manufacturer's instructions, etc.)? ☐ Yes ☐ No

Was the employee provided with safety training prior to performing the task? ☐ Yes ☐ No

Was training documented? ☐ Yes ☐ No

Why did the injury happen? *(Provide details, such as: if injury was due to unsafe acts or conditions, inadequate training or equipment, etc.)*

Supervisor's corrective actions (describe):

Specific location of the accident *(e.g. building name, room number, parking lot name, staircase location, etc.)*

Date Reported:	Accident State:

Accident Summary – Detailed
(Describe the accident/illness and how it occurred. Be specific.)

Initial Medical Treatment

☐ None Required ☐ Refused ☐ First Aid Only
☐ Physician/Treatment Facility Visit.
Please state where *(i.e. Medical Office, Cutler Health, or Doctor's Name)*:
☐ Emergency Room Visit
Please state where:
Was the employee transported to the Emergency Room via ambulance? ☐ Yes ☐ No

Was employee admitted into the hospital overnight? ☐ Yes ☐ No

Did the employee lose consciousness? ☐ Yes ☐ No

Was employee exposed to another person's blood or bodily fluids? ☐ Yes ☐ No	Witnesses (fill in below): Name/Phone: Name/Phone:
Loss Cause *(e.g. repetitive motion, struck by, struck against, exposure to heat, exposure to chemical, slip/trip/fall, etc.)*:	
Loss Type / Specific Injury or Illness *(e.g. tendonitis, carpal tunnel, fracture, sprain/strain, burn, abrasion, laceration, etc.)*:	
Body Part *(i.e. lungs, both wrists, right eye, ears, left leg, right thumb, lower back, etc.)*	
Job Code: ☐ Driver ☐ College Professional/Clerical ☐ Child Care ☐ All Other	Did employee lose days away from work? ☐ Yes ☐ No Date Last Worked: Date Returned to Work:
Salary Continued in Lieu of Compensation? ☐ Yes ☐ No *(Select "yes" unless the employee is receiving Workers' Compensation)* Full Wages Paid on Day of Injury? ☐ Yes ☐ No	
Employment: ☐ Full Time ☐ Part Time ☐ Volunteer	
Hire Date:	Rate of Pay: *Indicate if hourly, biweekly, monthly or annually*
Employee's Job Title (at UMaine):	
Date employee notified employer of lost time:	
Does employee work for another employer? If Yes, what is the Employer's Name:	
OSHA Recordable? ☐ Yes ☐ No *An OSHA recordable is defined as days away from work, restricted work activity or job transfer, medical treatment beyond first aid, or loss of consciousness.*	
This form completed by (Name):	
Title:	
Your email:	Phone #: