INJURY/ILLNESS ACCIDENT REPORT

Instructions: The supervisor/manager is responsible for the accurate completion and submittal of this form (electronically), within 24 hours, to their Local Human Resources Contact for all workplace incidents, injuries, accidents and near misses. The affected employee and witnesses should be consulted (if possible) to gather the most complete and accurate description of the incident. ***ALL FIELDS ON THE FORM MUST BE COMPLETED***

Send Completed Claim Form To: Heidi Shea, HR Consultant hshea@seas.harvard.edu Fax: 617.496.2260	**CALL EH&S at (617) 495-5560 immediately if a work-related fatality, inpatient hospitalizations, amputation or losses of an eye.**

CLAIMANT INFORMATION

Name:	**HUID:**
Address1:	**Home Phone:**
Address2:	**Work Phone:**
City, State, Zip:	**Home Email:**
Date of Birth:	**Work Email:**
Marital Status: Choose an item	**Gender:** Choose an item

INCIDENT INFORMATION

Accident Occurred on Harvard Premises: Choose an item	**Date Incident Reported:**
Date of Incident:	**Time of Incident:**
Accident State: Choose an item	**State of Jurisdiction:** Choose an item

Specific Location [Building/Room/Area] Where Injury/Illness Occurred:

Accident/Injury/Illness Description (50 character limit): Tell Us How the Injury/Illness Occurred. *Examples "When ladder slipped on wet floor, worker fell 20 feet"," Worker developed soreness in wrist over time."*

What Were the Employee Doing Immediately Prior to the Injury/Illness? *Describe the activity as well as the tools, equipment or materials the employee was using. Be Specific.*

What Object or Substance or Motion Directly Injured the Employee or Caused the Illness*? Examples "Concrete floor", "Chlorine"* Choose an item

Did the Accident/Injury/Illness Involve a Needle or Device (e.g.: scalpel, broken glass, dental wire, etc.) That Was Potentially Contaminated With Blood or Other Potentially Infectious Material? Choose an item

Type of Injury/Illness: Choose an item	**Body Part:** Choose an Item

Initial Medical Treatment: Choose an Item

If Treatment Was Given Away From the Worksite, Where Was it Given?: *Facility, Street, City, State, Zip*

Could This Injury/Illness Result in HIV Infection? **YES** ◯ **NO** ◉	If Yes, seek confidential HIV blood testing at UHS or an approved laboratory within 5 calendar days of the incident. See Harvard's Work-Related HIV Benefit Plan.

WITNESSES							
Name:				**Title:**			
Email:							
Phone:				**Alternate Phone:**			
Name:				**Title:**			
Email:							
Phone:				**Alternate Phone:**			
JOB INFORMATION							
TUB: Choose an Item							
Empclass: Choose an item							
Department: Choose an item							
Employment: Choose an item							
Time Shift Started:				**Time Shift Ended:**			
EE Lost More Than 4 hours of Work: Choose an item				**How Many Hours Lost:**			
Pay Per Hour:				**Multiple Job Indicators:** Choose an item			
Blended Rate: Choose an item				**Pay Schedule:** Choose an item			
Weekly Schedule:	**Mon** ☐	**Tues** ☐	**Wed** ☐	**Thurs** ☐	**Fri** ☐	**Sat** ☐	**Sun** ☐
Hours Worked per Week:				**Return to Work Date:**			
Supervisor Name:				**Supervisor Phone:**			
WORKERS' COMPENSATION ONLY							
Job Code: Choose an item							
Lost Time: Choose an item				**Date Last Worked:**			
Returned to Work: Choose an item				**Returned Light Duty Date:**			
OR Returned Full Duty Date:				**Employee Died Because of Injury:** Choose an item			
AUTHORIZATION							
Completed By:				**Date:**			
Title:				**Phone:**			