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THE CATHOLIC UNIVERSITY OF AMERICA
WORKERS' COMPENSATION CLAIM FORM
FIRST REPORT OF INJURY OR OCCUPATIONAL ILLNESS

USE THIS FORM TO REPORT ACCIDENT OR ILLNESS TO THE OFFICE OF HUMAN RESOURCES **THE DAY IT OCCURS**. IF THE EMPLOYEE IS NOT AVAILABLE TO SIGN THIS FORM, THE SUPERVISOR MAY SIGN ON BEHALF OF THE EMPLOYEE. D**O NOT DELAY REPORTING INCIDENT BECAUSE ALL INFORMATION IS NOT AVAILABLE.** REPORT EVEN IF YOU HAVE ONLY THE NAME AND DATE AND TYPE OF INJURY.

PART I. TO BE COMPLETED BY EMPLOYEE OR SUPERVISOR

Employee's Name _____ SSN _____
Last First MI
Birth Date _____ Sex: ◯ M ◯ F Home Phone _____

Address _____

Date of Hire _____ Hourly wage $ _____

Check regular work days ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU

Normal starting time _____ Hours worked per day _____ ◯ Full-time ◯ Part-time

Department regularly employed _____ Occupation when injured _____

INJURY

Date _____ Time _____ Location of incident _____

When was the employee's department first notified? Date _____ Time _____

Did employee stop work immediately? ◯ Yes ◯ No If no, explain why _____

Was injured paid in full for this day? ◯ Yes ◯ No Did employee lose any time from work? ◯ Yes ◯ No

Disability began: Date _____ Time _____ If returned to work, Date _____ Time _____

Was employee doing usual work when incident occurred? ◯ Yes ◯ No If no, explain why _____
_____

Describe in full detail how the incident happened (What was the employee doing at the time? What machines, tools, or instruments were involved and how? Were any other parties involved?) _____
_____
_____

Describe the nature of the injury including injury type and body part affected (use examples under injury type listed in attached chart).
_____
_____

Names of Witnesses (if any) _____

Attending physician, address and date of treatment (if hospital involved indicate name of hospital) _____
_____

Signature of Employee _____ Date _____

PART II. TO BE COMPLETED BY THE SUPERVISOR

Did you investigate the incident? ◯ Yes ◯ No If no, please state your reasons _____

From your investigation answer the following:

Type of accident: _____

Primary cause of accident (use examples from codes) _____

Corrective actions necessary _____

If fatal, give date of death _____

Name of Supervisor (please print) _____ Phone _____

Signature of Supervisor _____ Date _____

PLEASE NOTE: In the case where an employee loses time after this form has been submitted, please send a memo to the Office of Human Resources stating the exact date and time lost, for how many days employee was paid, and the date and time the employee returned to work.

Send all the original medical bills and doctor's leave certificates which are related to this incident to the Office of Human Resources as soon as possible.

IF AN INJURY OR OCCUPATIONAL ILLNESS RESULTS IN A FATALITY OR A HOSPITAL ADMISSION OF THREE OR MORE EMPLOYEES, NOTIFY ENVIRONMENTAL HEALTH AND SAFETY IMMEDIATELY.

WORKERS' COMPENSATION CODE NUMBERS

INJURY TYPE	BODY PART AFFECTED	BODY MOVEMENT	PRIMARY CAUSE
001 SPRAIN/STRAIN/OTHER MUSCLE INJURY	310 HEAD/FACE (EXCLUDING EYES)	001 LIFT FROM FLOOR LEVEL	001 OVER EXERTION
002 DERMATITIS/SKIN RASH	311 EYE	002 LIFT FROM BENCH LEVEL	002 STRUCK BY OBJECT
003 FRACTURE	312 NECK	003 LIFT FROM ABOVE BENCH LEVEL	003 STRUCK AGAINST OBJECT
004 CUT/LACERATION/ PUNCTURE OF SKIN	313 EAR/HEARING	004 LIFT FROM BELOW GROUND (PIT)	004 CAUGHT IN, UNDER, BETWEEN
005 BRUISE/CONTUSION/ CRUSH INJURY	314 TOOTH	005 OTHER LIFT TYPE	005 FALL FROM ELEVATED LEVEL
006 MULTIPLE INJURIES OF BODY	320 ARM/SHOULDER/ELBOW	006 REACH WHILE STANDING	006 FALL ONTO SAME LEVEL
007 DISLOCATION	321 WRIST/HAND	007 REACH WHILE SITTING	007 REACTION TO EXTERNAL
008 HERNIA/RUPTURE	322 FINGER	008 REACH OVERHEAD	008 MOTOR VEHICLE ACCIDENT (HIGHWAY)
009 BURN (THERMAL)	323 THUMB	009 REACH WHILE BENDING	009 MOTOR VEHICLE ACCIDENT (NON-HWY)
010 BURN (CHEMICAL)	330 TRUNK (EXCLUDING BACK)	010 TWIST AT TRUNK	010 CONTACT W/TEMPERATURE EXTREME
011 NERVOUS SYSTEM IMPAIRMENT	331 BACK	011 BEND WHILE STANDING	011 CONTACT W/CHEMICAL HAZARD
012 HEARING IMPAIRMENT	332 HIP	012 BEND WHILE SITTING	012 NOISE EXPOSURE
013 AMPUTATION/ ENUCLEATION	340 LEG/KNEE/THIGH	013 STANDING UPRIGHT	013 ABRADED/SCRAPED/ SCRATCHED
014 SCRATCHES/SLIGHT ABRASIONS	341 FOOT/ANKLE	014 SITTING UPRIGHT	014 EXPLOSION
015 CONCUSSION	342 TOE	015 KNEELING	015 CONTACT W/ELECTRIC CURRENT
016 INFLAMMATION/ IRRITATION	350 MULTIPLE BODY PARTS	016 SQUATTING	016 CONTACT W/SHARP OBJECT
017 SYSTEMIC POISONING	360 RESPIRATORY SYSTEM	017 RUNNING WITH NO LOAD	017 UNSAFE ACT
018 INSECT STING/BITE	370 CENTRAL NERVOUS SYSTEM	018 RUNNING WITH LOAD	018 POOR JUDGEMENT
019 FOREIGN BODY IN EYE	380 GASTROINTESTINAL SYSTEM	019 WALKING WITH NO LOAD	019 IGNORED POLICY/PROCEDURE
020 LOSS OF CONSCIOUSNESS	385 REPRODUCTIVE SYSTEM	020 WALKING WITH LOAD	020 LACKED REQUIRED PERSONAL PROTECTIVE EQUIPMENT
021 ELECTRIC SHOCK	390 CIRCULATORY SYSTEM	021 CLIMBING WITH NO LOAD	021 USED IMPROPER PPE
022 HEAT STRESS	398 OTHER	022 CLIMBING WITH LOAD	022 CLUTTERED WORK AREA
023 RESPIRATORY DISORDER	399 NONE/NOT APPLICABLE	023 PUSHING LOAD WHILE SITTING	023 WEATHER CONDITIONS (SNOW)
444 CUMULATIVE TRAUMA DISORDER		024 PULLING LOAD WHILE SITTING	024 WEATHER CONDITIONS (RAIN)
555 PSYCHOLOGICAL STRESS		025 PUSHING LOAD WHILE STANDING	025 WEATHER CONDITIONS (DARK)
666 MICROBIAL INFECTION		026 PULLING LOAD WHILE STANDING	026 INADEQUATE LIGHTING/VISIBILITY
777 OTHER		027 PULLING LOAD UP GRADE	027 USED IMPROPER TOOL/EQIPMENT
888 NEEDS INVESTIGATION TO DETERMINE		028 PUSHING LOAD UP GRADE	028 DEFECTIVE TOOL/EQUIPMENT
999 NONE/NOT APPLICABLE		029 REPETITIVE BODY MOTION	029 REPETITVE MOTION EXPOSURE
		030 CONCENTRATED EYE CONTACT	030 INADEQUATE INSTRUCTION BY SUPERVISOR
		031 LAYING PRONE	031 INADEQUATE DEPARTMENTAL COOPERATION
		032 OTHER	032 DUTIES NOT UNDERSTOOD
		033 UNKNOWN	033 CONFLICTING TASKS
		034 NONE/NOT APPLICABLE	034 ORDERS GIVEN, NOT FOLLOWED
			035 CONFLICTING TASKS OBJECTIVES
			036 DEFECTIVE WALKING SURFACE
			037 DID NOT RECOGNIZE OVERT HAZARD
			038 INTOXICATION/DRUG USAGE
			888 HORSEPLAY
			998 OTHER
			999 UNKNOWN