**\*\*\*MUST BE COMPLETED WITHIN 48 HOURS OF INCIDENT\*\*\***

**Mail To:** Lori Sullivan, Benefits Manager, Quinn Building, 3rd Floor

100 Morrissey Blvd, Boston, MA 02125

**Or Scan To**: [lori.sullivan@umb.edu](mailto:lori.sullivan@umb.edu)

**Or Fax:** (617) 287-5179

TODAY’S DATE:

**Please complete the following information about the employee involved in the incident:**

NAME:

(Last) (First) (Middle)

HOME ADDRESS:

(Street) (State) (Zip Code)

PHONE NUMBER: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** EMPLOYEE ID#**:**

BIRTHDATE: AGE: **\_\_\_\_\_\_** SEX: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

EMPLOYEE’S TITLE: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DEPARTMENT: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DATE OF HIRE: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

INCIDENT REPORTED TO: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DATE REPORTED: **\_\_\_\_\_\_\_\_\_\_\_\_**

NAME AND TITLE OF SUPERVISOR: **\_\_\_\_\_\_\_\_\_\_\_\_**

SUPERVISOR’S PHONE: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NAME OF WITNESS: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** NAME OF WITNESS: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

WITNESS PHONE: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** WITNESS PHONE: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DATE OF INCIDENT: **\_\_\_\_\_** TIME OF INCIDENT: **\_\_\_\_** **\_\_a.m./p.m.**

NAME:

(Last) (First) (Middle)

TIME WORK BEGAN ON DAY OF INCIDENT:**a.m./p.m.**

INCIDENT LOCATION:

DID AN INJURY OCCUR AS A RESULT OF THIS INCIDENT?

YES\_\_\_ (COMPLETE REMAINDER OF THIS FORM)

NO\_\_\_\_ (SKIP NEXT SECTION TO SIGNATURE AT END OF FORM)

NATURE OF INJURY:

WAS EMPLOYEE ENGAGING IN USUAL JOB ACTIVITIES AT TIME OF INJURY? , IF NO, EXPLAIN:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DESCRIBE HOW INJURY OCCURRED (INCLUDE WHAT EMPLOYEE WAS DOING PRIOR TO INJURY OCCURRING):**\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

WHAT BODY PART INJURED?: **\_\_\_\_\_\_\_\_\_\_\_\_\_**

SELECT ONE OR MORE INJURY CATAGORIES:

\_\_\_Assault \_\_\_Exposure \_\_\_Moving/Walking

\_\_\_Burn \_\_\_Fall \_\_\_Repetitive Use

\_\_\_Cut \_\_\_Lifting \_\_\_ Result of Violent Act

\_\_\_Equipment \_\_\_Motor Vehicle Accident \_\_\_Stress/Heart Attack

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEVERITY OF INJURY: Please indicate your initial impression as to the severity of the claimed injury:

(1) Minor injury; no likely lost time; no likely medical bills

(2) Small injury; no likely lost time; possible medical bills

(3) Moderate injury; possible lost time; probable medical bills

(4) Significant injury; probably 0 to 5 days of lost time and medical bills

(5) Severe injury; probably 5 plus days lost time and medical bills

DID EMPLOYEE SEE A PHYSICIAN? \_\_\_\_\_\_ DATE OF TREATMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:

(Last) (First) (Middle)

DID EMPLOYEE GO TO THE EMERGENCY ROOM? \_\_\_\_\_

WAS EMPLOYEE ADMITTED TO THE HOSPITAL?\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S NAME AND ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOSPITAL’S NAME AND ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE

I certify that the injury described above was sustained in the performance of my duties as an employee of UMass Boston and that this injury was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication or influence of illegal drugs or misuse of medication.

I am attaching any information I feel may be useful to managing this claim.

EMPLOYEE’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_

I acknowledge that I received this report from the employee.

I acknowledge that I completed this form on behalf of the employee.

SUPERVISOR’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_

CC: Department Head