**Office of the President**
**University of Massachusetts**

# NOTICE OF INJURY/ILLNESS REPORT

**This form is intended for internal use for all HRD (Human Resources Division)/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed within 48 hours of an Industrial Accident.**

Employee. #: _____ Date of Injury/Illness: _____

Agency: University of Massachusetts - President's Office

Agency mailing address: 50 Washington Street, Suite 3000, Westborough, MA 01581

Name: _____
(First) (Middle) (Last)

Sex: ☐ Male ☐ Female

Employee Home Address: _____ City:_____State:_____Zip:_____

Home Telephone: _____ Date of Birth _____

State Hire Date: _____Department Hire Date: _____

Status: ☐ Full Time Employee ☐ Part Time Employee Work Hours/Wk:_____

Shift: ☐ 1st ☐ 2nd ☐ 3rd Number of scheduled days off per week:_____

Department: _____

Occupation: (Official Position Title)_____

Functional Title: _____

Payroll Funding Source: ☐ State Payroll ☐ Trust Funded ☐ Federal Funded

Job Code: _____ Position Type: _____ Position #: _____ Union Code: _____

Time of event: _____ ☐ am ☐ pm Date Reported: _____

Time work began on day of event: _____ ☐ am ☐ pm

Event occurred: ☐ Before ☐ During ☐ After Work shift

What was employee doing just before the event occurred, d*escribe the activity as well as any tools, equipment or material the employee was using. Be specific. Examples: (*Walking down the hallway carrying supplies. Restraining a patient. Pouring cleaning solution into a bucket in order to wash the floor.)

Third Party Claim: ☐Yes ☐No

How did the injury or illness occur: *Example: (*Employee tripped over an electrical cord and fell to the floor; Patient was flailing and hit the employee; Cleaning solution splashed while being poured.)

What was the source of the injury or illness? *Source means the object or substance that directly harmed the employee. What object or substance directly harmed the employee?" Example:(*The floor; A patient; Cleaning solution)

Nature of Injury or illness: *Describe the Nature of the injury.* Example: (strained back; contusion; disorders of the eye)

_____

Body part(s) affected, a n*arrative of body parts affected.* Example: (low back; face, arm; eyes)

_____

Injury/Illness detail (Choose Only from the Attached List):

Select Body Part:_____

Select Injury/illness:_____

Select One or More Event Categories:

| | | |
|---|---|---|
| ☐ Fall | ☐ Lifting | ☐ MVA (Motor Vehicle Accident) |
| ☐ Assault | ☐ Exposure to Harmful Substances | ☐ Repetitive Use |
| ☐ Equipment | ☐ Moving/Walking | ☐ Stress/Heart Attack |
| ☐ Burn | ☐ Cut | ☐ Restraint |
| ☐ Other _____ | ☐ Needlestick/Bloodborne Pathogen Exposure | |

Severity of Injury or Illness:

☐ (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

Where The Injury Occurred:

Building: _____

Injury/Illness Location: _____

Was the event the result of a violent act? ☐ Yes ☐ No

Was the employee engaging in usual job activities: ☐ Yes ☐ No

If no, explain:

Injury reported to:_____

Did the injured/ill worker:

a. Lose consciousness? ☐ Yes ☐ No

b. Require medical treatment more than first aid? ☐ Yes ☐ No

c. Have an injury from a contaminated needlestick or other sharp device? ☐ Yes ☐ No

d. Have a significant work-related injury/illness diagnosed by a health care professional? ☐ Yes ☐ No

e. Require transfer to another job or modified duty? ☐ Yes ☐ No

If employee died as a result of injury/illness, what was the date of death? _____

**Supervisor:** Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain

**Manager:** Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain:

Was the event witnessed? ☐ Yes ☐ No

**If Yes, provide the names of witnesses and ask that each prepare a witness statement in their own handwriting and fax those statements to your claims adjuster.**

Witness: Name_____ Title_____Tel_____

Name_____ Title_____Tel_____

Did the employee seek medical attention? ☐ Yes ☐ No

If so, where?

a. Facility: _____

b. Street: _____

c. Town: _____

d. Zip Code: _____

Did the employee seek medical attention away from the worksite? ☐ Yes ☐ No

Was employee treated in an emergency room? ☐ Yes ☐ No

Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

Is employee a disabled veteran or has any other known disability? ☐ Yes ☐ No ☐ Unknown

Do you feel the employee would benefit from any referral to Rehabilitation? ☐ Yes ☐ No ☐ Unknown

Do you feel the claim warrants further investigation? ☐ Yes ☐ No

Please attach any information you feel would be useful to HRDWC Unit in managing this claim.
Please attach employee job description.

Signature_____ Date:_____

Position:_____

Attachment for Body Parts and Injuries

| Body Parts | | |
|---|---|---|
| **Head** | Hip/Buttocks/Groin (Buttocks) | **Upper Extremities** |
| Brain | Hip/Buttocks/Groin (Groin) | Arm(s), unspecified (Left) |
| Ear(s), unspecified | Hip/Buttocks/Groin (Hips) | Arm(s), unspecified (Right) |
| Ear(s), external | Shoulder(s) (Left) | Arm(s), unspecified (Both) |
| Ear(s), internal | Shoulder(s) (Right) | Arm(s), unspecified (Armpit) |
| Eye(s) (Left) | Shoulder(s) (Both) | Arm(s), upper (Left) |
| Eye(s) (Right) | Trunk, Multiple | Arm(s), upper (Right) |
| Eye(s) (Both) | **Lower Extremities** | Arm(s), upper (Both) |
| Face, unspecified | Leg(s), unspecified (Left) | Elbow(s) (Left) |
| Jaw, Chin | Leg(s), unspecified (Right) | Elbow(s) (Right) |
| Mouth & Throat (Lips) | Leg(s), unspecified (Both) | Elbow(s) (Both) |
| Mouth & Throat (Multiple) | Knee(s) (Left) | Arm(s), lower (forearm) (Left) |
| Mouth & Throat (Tongue) | Knee(s) (Right) | Arm(s), lower (forearm) (Right) |
| Mouth & Throat (Tooth/teeth) | Knee(s) (Both) | Arm(s), lower (forearm) (Both) |
| Mouth & Throat (Unspecified) | Leg(s), lower (e.g. calf, shin) (Left) | Arm(s), multiple (Left) |
| Mouth & Throat (Internal (e.g. vocal cords, larynx)) | Leg(s), lower (e.g. calf, shin) (Right) | Arm(s), multiple (Right) |
| Nose | Leg(s), lower (e.g. calf, shin) (Both) | Arm(s), multiple (Both) |
| Face, multiple | Leg(s), multiple (Left) | Wrist(s) (Left) |
| Face (Cheeks) | Leg(s), multiple (Right) | Wrist(s) (Right) |
| Face (Forehead) | Leg(s), multiple (Both) | Wrist(s) (Both) |
| Scalp | Leg(s), upper (e.g. thigh, hamstring) (Left) | Hand(s), not wrist/fingers (Left) |
| Skull | Leg(s), upper (e.g. thigh, hamstring) (Right) | Hand(s), not wrist/fingers (Right) |
| Head, Multiple | Leg(s), upper (e.g. thigh, hamstring) (Both) | Hand(s), not wrist/fingers (Both) |
| Head | Ankle (Left) | Finger(s) |
| **Neck** | Ankle (Right) | Upper Extremities, multiple (Left) |
| Neck & cervical vertebrae | Ankle (Both) | Upper Extremities, multiple (Right) |
| **Trunk** | Foot or Feet, except ankle/toe (Left) | Upper Extremities, multiple (Both) |
| Trunk, UNS | Foot or Feet, except ankle/toe (Right) | **Other** |
| Abdomen, internal organs/hernia | Foot or Feet, except ankle/toe (Both) | Other (Body system) |
| Back | Toe(s) | Other (Multiple body parts) |
| Chest/Breastbone (Internal organs) | Lower Extremities, multiple (Left) | Non-Classifiable |
| Chest/Breastbone (Ribs, breastbone) | Lower Extremities, multiple (Right) | |
| | Lower Extremities, multiple (Both) | |

| Injuries | |
|---|---|
| **Acute Injuries** | **Mental disorders** |
| Amputation, enucleation | Mental disorders (Anxiety attacks) |
| Asphyxia, suffocation | Mental disorders (Other mental disorder or syndrome) |
| Burn, heat | Mental disorders (Stress) |
| Burn, chemical | **Other Work-related diseases/disorders** |
| Concussion | Other occupational disease |
| Contusion, crushing, bruise | Diseases of central nervous system |
| Cut, laceration, puncture (Except needlestick injury) | Diseases of peripheral nerves and ganglia |
| Cut, laceration, puncture (Needlestick/sharp injury ) | Disease of the blood and blood forming organs |
| Cut, laceration, puncture (Splinter, chip (foreign body)) | Disease of the gastro-intestinal tract |
| Dislocation | Carpal tunnel syndrome |
| Fracture | **Poisoning and toxic effects** |
| Effects of exposure to low temperature | Other poisoning due to toxic materials |
| Effects of environmental heat | Effects of lead |
| Hernia, rupture | **Respiratory conditions** |
| Effects of radiation | Other respatory condition |
| Scratches, abrasion | Upper respiratory condition (e.g. allergic rhinitis) |
| Sprains, strains | Asthma |
| Multiple injuries | Asbestosis |
| Effects of atmospheric pressure | Silicosis |
| Bite/Burn/Other Injury (Bite, animal) | Influenza/Pneumonia (Influenza) |
| Bite/Burn/Other Injury (Bite, human) | Influenza/Pneumonia (Pneumonia) |
| Bite/Burn/Other Injury (Bite, insect) | **Skin conditions** |
| Bite/Burn/Other Injury (Burn, other) | Dermatitis |
| Bite/Burn/Other Injury (Other injury) | Infections of the skin |
| Electric shock/electrocution | Other skin conditions |
| **Heart/Circulatory System Conditions** | **Tumor, cancer** |
| Heart/Circulatory System (Heart condition/attack) | Tumor, unspecified |
| Heart/Circulatory System (High blood pressure) | Malignant Tumor |
| Heart/Circulatory System (Stroke or other circulatory condition) | Benign Tumor |
| **Hearing and eye disorders** | **Symptoms, ill defined conditions** |
| Hearing loss or impairment | Symptoms, ill defined conditions (Back pain, hurt back) |
| Conjunctivitis | Symptoms, ill defined conditions (Chest pains) |
| Other diseases of the eye | Symptoms, ill defined conditions (Dizziness) |
| **Infectious or parasitic diseases** | Symptoms, ill defined conditions (Headaches, migraine) |
| Tetanus | Symptoms, ill defined conditions (Nausea, vomiting) |
| Tuberculosis | Symptoms, ill defined conditions (Pain/Soreness, except back or chest) |
| Infectious/Parasasitic Diseases (Lyme disease) | Symptoms, ill defined conditions (Sick building syndrome) |
| Infectious/Parasasitic Diseases (Other infectious or parasitic diseases) | Symptoms, ill defined conditions (Other symptoms and ill defined conditions) |
| Hepatitis - viral | **Other** |
| **Inflammation of the joints or tendons** | No injury or illness |
| Joint Inflammation, etc. (Arthritis) | Damage to prosthetic devices |
| Joint Inflammation, etc. (Bursitis) | Non-classifiable (Exposure to saliva/body fluids) |
| Joint Inflammation, etc. (Other Inflammation of the joints) | Non-classifiable (Non-classifiable) |
| Joint Inflammation, etc. (Sciatica) | Complications peculiar to medical care |
| Joint Inflammation, etc. (Tendonitis) | |

# WORKER'S COMPENSATION AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Employee's name _____

Employee ID Number _____

Home Address _____

_____

Telephone Number _____

EMPLOYING AGENCY AND LOCATION:

University of Massachusetts - President's Office
50 Washington Street, Suite 3000
Westborough, MA 01581
774-545-8778

DATE OF INJURY: _____

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, ***any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law***. I understand that HRD may share this information with my employer, medical and or vocational rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

SIGNATURE: _____ DATE: _____