Office of the President
University of Massachusetts

NOTICE OF INJURY/ILLNESS REPORT

This form is intended for internal use for all 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: 333 South Street; 4th Floor, Shrewsbury, MA 01545

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
333 South Street; 4th Floor
Shrewsbury, MA 01545
774-455-7568

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:_____