



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, *describe 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 *narrative 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:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Fall | <input type="checkbox"/> Lifting | <input type="checkbox"/> MVA (Motor Vehicle Accident) |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Exposure to Harmful Substances | <input type="checkbox"/> Repetitive Use |
| <input type="checkbox"/> Equipment | <input type="checkbox"/> Moving/Walking | <input type="checkbox"/> Stress/Heart Attack |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Cut | <input type="checkbox"/> Restraint |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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 respiratory 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/Parasitic Diseases (Lyme disease)	Symptoms, ill defined conditions (Sick building syndrome)
Infectious/Parasitic 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: _____