

RESEARCH CORPORATION OF THE UNIVERSITY OF HAWAII SUPERVISOR'S REPORT OF INDUSTRIAL INJURY

~~Fax (808) 956-5022 or email (rcuhr@rcuh.com) to RCUH HR within 24 hours of Injury/Illness/Accident
Original form should be sent to 2530 Dole Street, Sakamaki Hall D-100, Honolulu, HI 96822~~

(Part A and Part B **MUST** be completed)

1. EMPLOYEE'S NAME (Last, First, MI)		2. PROJECT NAME		3. CLASSIFICATION: <input type="checkbox"/> Regular <input type="checkbox"/> Student <input type="checkbox"/> Temporary <input type="checkbox"/> Volunteer	
4. EMPLOYEE'S RCUH ID#	5. EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code)			6. JOB TITLE	
7. DATE OF INJURY	8. DATE INJURY REPORTED TO SUPERVISOR	9. TIME WORKSHIFT BEGAN _____ : _____ A.M. / P.M.		10. TIME OF INJURY _____ : _____ A.M. / P.M.	
11. ACCIDENT LOCATION & ADDRESS (Ex., Loading dock north end; 2432 N. St. Hilo, HI)				12. WITNESS(ES) NAME (Last, First)	
13. HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened.)					
14. WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)					
15. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE? (e.g. the machine employee struck against or struck him, the vapor or poison inhaled or swallowed, etc.)					
16. EMERGENCY CARE AND PATIENT STATUS <input type="checkbox"/> First Aid Only (i.e., employee was <u>not</u> referred to hospital or doctor) <input type="checkbox"/> Referred to hospital/doctor, current status unknown <input type="checkbox"/> Treatment at hospital/doctor (complete name/address of physician below) _____ _____ _____					

17. EMPLOYEE STATUS

Was employee paid in full for day of accident? Yes No

Has employee returned to work? Yes No If "Yes", enter date returned: _____

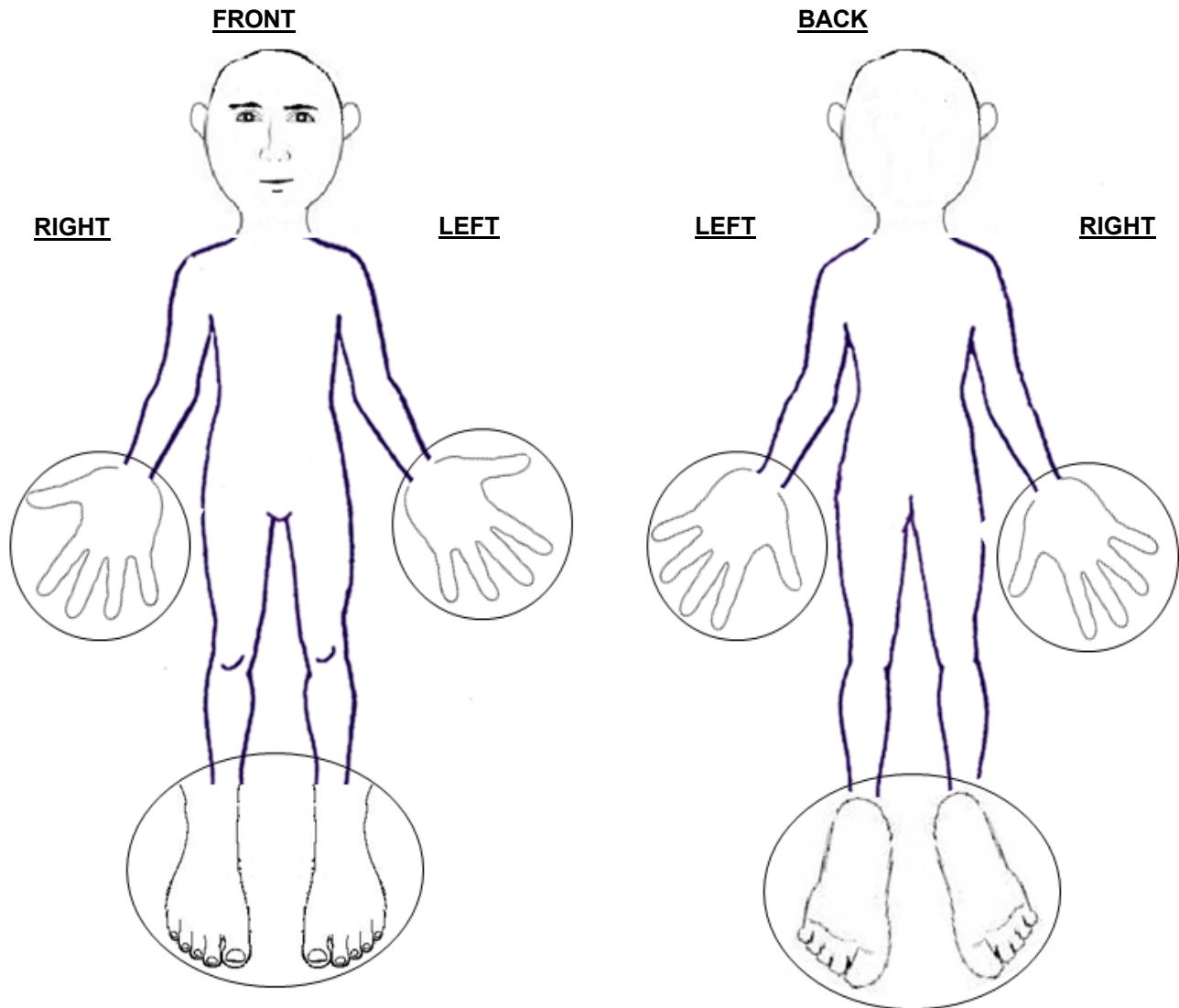
Will employee lose time from work? Yes No If "Yes", please explain: _____

Indicate any other information about the employee's status: _____

18. IDENTIFY SPECIFIC BODY PART(S) INJURED.

***Describe the injury/illness

***Mark ("X") the injured body part(s) on diagram below



STATEMENT OF CERTIFICATION *(Any falsification of this report may result in disciplinary action)*

19. Supervisor's Signature

20. Date

21. Employee's Signature

22. Date

19a. Print Name/Phone Number/Fax/Email

21a. Print Name/Work & Home Phone Numbers/Email

PART B: ACCIDENT INVESTIGATION:

1. What type of safety equipment and/or procedure was involved in this work process? Did the employee use the equipment or follow the procedure?
2. What kind of actions do you plan to implement to prevent this type of accident from recurring?
3. Have you instructed the employee on how to avoid the recurrence?
4. Was a Safety Rule violated? If so, has the employee been disciplined for violating the safety rule?

Additional comments relating to Accident Prevention and/or investigation:

Supervisor's Signature

Project Safety Coordinator's Signature

Print Name/Phone Number/Fax/Email of Safety Coordinator

REVIEWED BY PRINCIPAL INVESTIGATOR:

Principal Investigator's Signature

Print Name/Phone Number/Fax/Email of Principal Investigator

REMINDERS:

1. If this is more than a "first aid" type injury or if the employee will lose time from work, the Employee must be seen by a Physician.
2. Complete and Attach EMPLOYEE/CLAIMANT CONSENT FORM (D-26) to this report and send both in to the RCUH Director of Human Resources immediately. Fax to 808/956-5022 AND mail original forms to 2530 Dole Street, Sakamaki Hall D-100, Honolulu, HI 96822.
3. Scan and email photo(s) of the injury(ies), location/work environment, object that may have caused the injury, etc. to rcuhr@rcuh.com.
4. Refer to RCUH 3.580 Workers' Compensation and 3.930 Safety and Accident Prevention Program policies for more information.
5. Provide the Employee with the "Guidelines to Employee Memo" located on the WC policy.