



ACCIDENT / INJURY INVESTIGATION REPORT INSTRUCTIONS

The attached form must be completed for injuries to employees, students, visitors or volunteers that occur on the job or during USI activities/events on or off campus.

Form should be completed within 24 hours of an incident.

CLAIMANT/INJURED (Employee, Student Worker, Student, Visitor, or Volunteer)

1. Complete entire 1st page, sign and date form.
2. Give both pages of Accident/Injury form to your supervisor or program director for completion.

SUPERVISOR OR PROGRAM DIRECTOR OF CLAIMANT/INJURED

1. Complete top section of page 2, sign and date form.
2. Return completed Accident/Injury Investigation Form to:
 - Human Resources – for injured employee or student worker.
 - Department of Risk Management – for injured student, visitor, or volunteer.

WORKER'S COMP MEDICAL CARE INSTRUCTIONS

AN EMPLOYEE OR STUDENT WORKER WHO IS INJURED WHILE PERFORMING THEIR DAILY WORK ROUTINE SHOULD SEEK:

NON-URGENT CARE – contact Human Resources at 812-461-5466 or 812-464-1781 for authorization of care.

- University Health Center (812-465-1250) on USI campus;
OR
- Deaconess Comp Center
 - 329 W. Columbia St., Evansville, IN 47710
812-450-7455 (located across from Deaconess Emergency Room)
 - 4506 N. 1st Avenue, Evansville IN 47710
(behind Burger King)
 - 10455 Orthopedic Dr., Newburgh, IN 47630
812-858-2100

EMERGENCY CARE

- ANY emergency room
- Deaconess Emergency Room - 600 Mary Street, Evansville 47710
- St. Mary's Emergency Room - 3700 Washington Ave., Evansville, IN 47714

Failure to follow these instructions could result in nonpayment of claim.



ACCIDENT / INJURY INVESTIGATION REPORT



UNIVERSITY OF SOUTHERN INDIANA

Form revised 5/1/15

MUST BE COMPLETED AND RETURNED WITHIN 24 HOURS OF ACCIDENT

Employee Student Worker Student Visitor Volunteer

Date of Report Time of Report A.M. P.M.

INJURED PERSON INFORMATION

Name of Injured Male Female

Permanent Address

City State Zip

Date of Birth USI Employee ID #

Telephone: Home / Cell Telephone: Work

Department Job Title

Number of hours scheduled to work per week

WITNESS INFORMATION

Name(s) of Witness

Telephone: Home / Cell Telephone: Work

STATEMENT OF INJURED PERSON OR WITNESS

Date of Accident Time of Accident A.M. P.M.

Location of Accident Type of Injury (e.g., strain, laceration)

Cause of Injury (e.g., slip/fall, lifting) Part of Body Affected (e.g., arm, leg, back)

Description of Accident

Is Treatment being sought? If so, where?

I authorize the release of any medical information relating to this injury / illness to the University's relevant insurers for review of this claim.

Signature of Injured Person Date

SECOND PAGE MUST BE COMPLETED BY SUPERVISOR OR PROGRAM DIRECTOR

TO BE COMPLETED BY THE SUPERVISOR OF THE ACTIVITY OR PROGRAM DIRECTOR
(attach additional information if necessary)

Name of Injured Person

Time employee's work day began (if employee)

A.M. P.M.

Evaluation of how accident occurred / contributing factors

Possible Preventative Actions (actions that have been / will be taken to prevent recurrence)

Work Phone of Supervisor or Program Director

Date signed

Signature of Supervisor or Program Director

Printed Name of Supervisor or Program Director

FOR HUMAN RESOURCES USE ONLY

Lost Time Yes No

Number of Days

Anticipated Release Date

Work Restrictions

Medical Treatment

EMPLOYEE OR STUDENT WORKER:

FILL IN FORM, FORWARD TO SUPERVISOR FOR COMPLETION. SUPERVISOR FORWARD TO HUMAN RESOURCES.

STUDENT, VISITOR OR VOLUNTEER: FILL IN FORM, FORWARD TO SUPERVISOR OR PROGRAM DIRECTOR. SUPERVISOR OR PROGRAM DIRECTOR PLEASE FORWARD TO THE DEPARTMENT OF RISK MANAGEMENT.