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 CLAIMAINT/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
    812-428-6161 (behind Burger King)
  - 10455 Orthopedic Dr., Newburgh, IN 47630
    812-858-2100

EMERGENCY CARE

- ANY emergency room
- Deaconess Emergency Room - 600 Mary Street, Evansville 47747
- 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.