

**Accident/ Injury Report Claim Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**An Accident/Injury Report must be completed and reported within 24 hours.**

Name of Employee/Student/Guest\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department Employee Works in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident/Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_AM \_\_\_PM

Location of Incident (be specific):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Reported \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_To Human Resources \_\_\_\_To Health Office

Description of Accident/Injury & how did it occur? (be specific)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did anyone witness the incident? \_\_\_No \_\_\_If Yes, Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment by Health Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Office Follow-up & Referral to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did the employee/student lose time from work/school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What date did the employee/student return to work/school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This report completed \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature Printed Name

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Employee/Student/Guest Signature Date Supervisor Signature Date

**FOR EMPLOYEES:** ORIGINAL TO HUMAN RESOURCES & HR SENDS COPY TO HEALTH SERVICE

Copies to Accountant in Finance Office, Director of Security on need-to-know basis only

**FOR STUDENTS:** ORIGINAL TO HEALTH SERVICES

Copies to Accountant in Finance Department and Director of Security on need-to-know basis

**PLEASE SEE OTHER SIDE OF THIS FORM**



**IMPORTANT NOTICE to FACULTY & STAFF**

For an employee’s accident or injury, when the Centenary University Accident and Injury Report is completed, it must be submitted to the Human Resources Department. Upon receipt, the Human Resources Department will notify the University’s Workers’ Compensation insurance carrier.

Once the University’s Workers’ Compensation insurance carrier has been notified, a CLAIM NUMBER will be assigned to this accident or injury. The Human Resources Department will contact the employee to inform you of your CLAIM NUMBER. In the event that you seek any medical treatment with regard to this reported accident or injury, you are required to inform your treating practitioner that this is a Workers’ Compensation accident or injury and you will be required to provide the treating practitioner with your Workers’ Compensation CLAIM NUMBER.

**Medical treatment, *other than emergency treatment*, must be with an authorized medical practitioner through the University’s Workers’ Compensation insurance carrier to avoid incurring personal expenses since Workers’ Compensation claims are ineligible under medical insurance plans.**

In order to identify an authorized medical practitioner for an employee’s work-related accident or injury, please contact the Human Resources Department at 908-852-1400 x2332 or x2268. The Human Resources Department will provide you with the telephone number for the appropriate representative at the University’s Workers’ Compensation insurance carrier. When you call the Workers’ Compensation insurance carrier, they will provide you with the names of authorized medical practitioner(s).

If you have any questions about this information, please contact the Human Resources Department at the above telephone number.

**PLEASE SEE OTHER SIDE OF THIS FORM**