RESEARCH CORPORATION OF THE UNIVERSITY OF HAWAII

SUPERVISOR'S REPORT OF INDUSTRIAL INJURY

CONFIDENTIAL

Upon completion of this report, please fax to (808) 956-9423 or email (rcuhhr@rcuh.com) to RCUH HR within 24 hours of Injury/Illness/Accident. Original form should be sent to John A Burns Hall, 4th Floor, 1601 East West Road, Honolulu, HI 96848

(Part A and Part B MUST be completed)

1. EMPLOYEE'S NAME *(Last, First, MI)*	**2. PROJECT NAME**	**3. CLASSIFICATION:** ☐ Regular ☐ Student ☐ Temporary ☐ Volunteer
4. EMPLOYEE'S RCUH ID#	**5. EMPLOYEE'S ADDRESS** *(No., Street, City, State, Zip Code)*	**6. MARITAL STATUS** ☐ Single ☐ Married
7. DATE OF INJURY	**8. JOB TITLE**	**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. DATE INJURY REPORTED TO SUPERVISOR** (MM/DD/YY)	**13. WITNESS(ES) NAME** *(Last, First)*

14. HOW DID THIS ACCIDENT OCCUR? *(Please fully describe the events that resulted in injury or occupational disease. Explain what happened.)*

15. DESCRIBE THE SURROUNDING/ENVIRONMENT WHERE THE INJURY/ILLNESS OCCURRED (e.g. steep, wet slippery slope, etc.)

16. WHAT WAS THE EMPLOYEE DOING WHEN INJURED OR BECAME ILL? *(Please be specific. Identify tools, equipment or material the employee was using.)*

17. 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.)*

18. EMERGENCY CARE AND PATIENT STATUS

☐ First Aid Only (i.e., employee was not referred to hospital or doctor)
☐ Referred to hospital/doctor, current status unknown (provide medical note if treated)
☐ Treatment at hospital/doctor (provide medical note and include doctor contact information below)

Physician Name:	
Address/Hospital Name:	
Phone Number:	
Email:	

19. EMPLOYEE STATUS

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

Has employee returned to work? ☐ Yes or ☐ No If "Yes", enter date returned: _____/_____/_____ (MM/DD/YY)

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

_____

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

_____

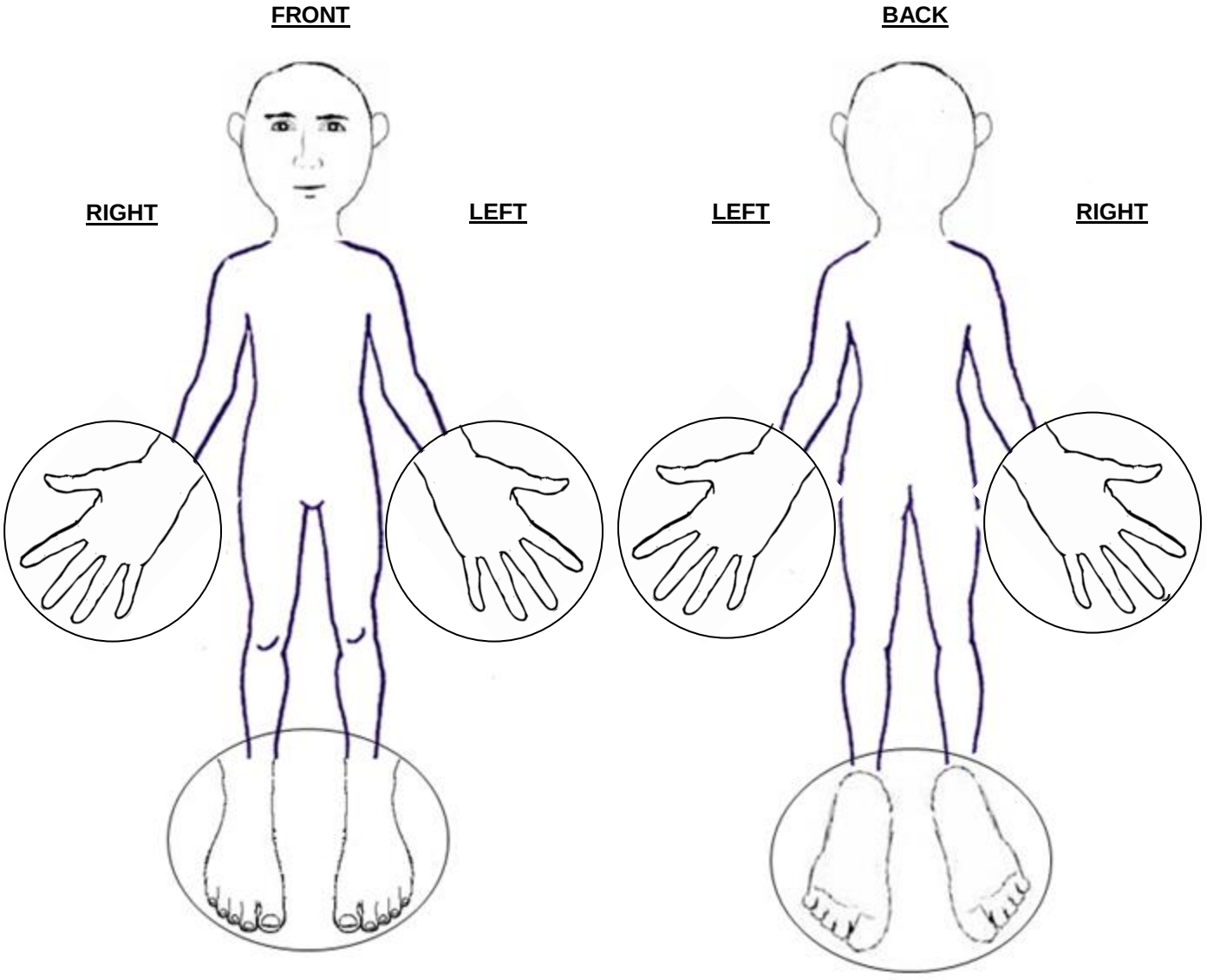
20. IDENTIFY SPECIFIC BODY PART(S) INJURED.

***Describe the injury/illness: _____

_____

_____

***Mark ("X") the injured body part(s) on diagram below and have employee initial by the injured body part(s).



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? How?

4. Was a Safety Rule violated? If so, has the employee been disciplined for violating the safety rule?

5. Please include photographs of the accident site to help better describe the location, environment, or other factors that caused/contributed to the accident. Number each photo and provide an explanation of what each photo represents. **DO NOT** include photos of the injury or injured employee.

Additional comments relating to Accident Prevention and/or investigation:

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

_____ Employee Name	_____ Employee Signature	_____ Date
_____ Work Phone Number	_____ Home Phone Number	_____ E-mail Address
_____ Supervisor Name	_____ Supervisor Signature	_____ Date
_____ Phone Number	_____ Fax Number	_____ E-mail Address
_____ Project Safety Coordinator Name	_____ Project Safety Coordinator Signature	_____ Date
_____ Phone Number	_____ Fax Number	_____ E-mail Address

REVIEWED BY PRINCIPAL INVESTIGATOR:

_____ Principal Investigator Name	_____ Principal Investigator Signature	_____ Date
_____ Phone Number	_____ Fax Number	_____ E-mail Address

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 (B-4) to this report and send both in to the RCUH Director of Human Resources immediately. Fax to 808/956-9423 AND mail original forms to John A Burns Hall 4th Floor Makai Wing, 1601 East West Road, 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 rcuhhr@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.