RCUH Research Corporation of the University of Hawai'i

Human Resources Department

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 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:_____

_____

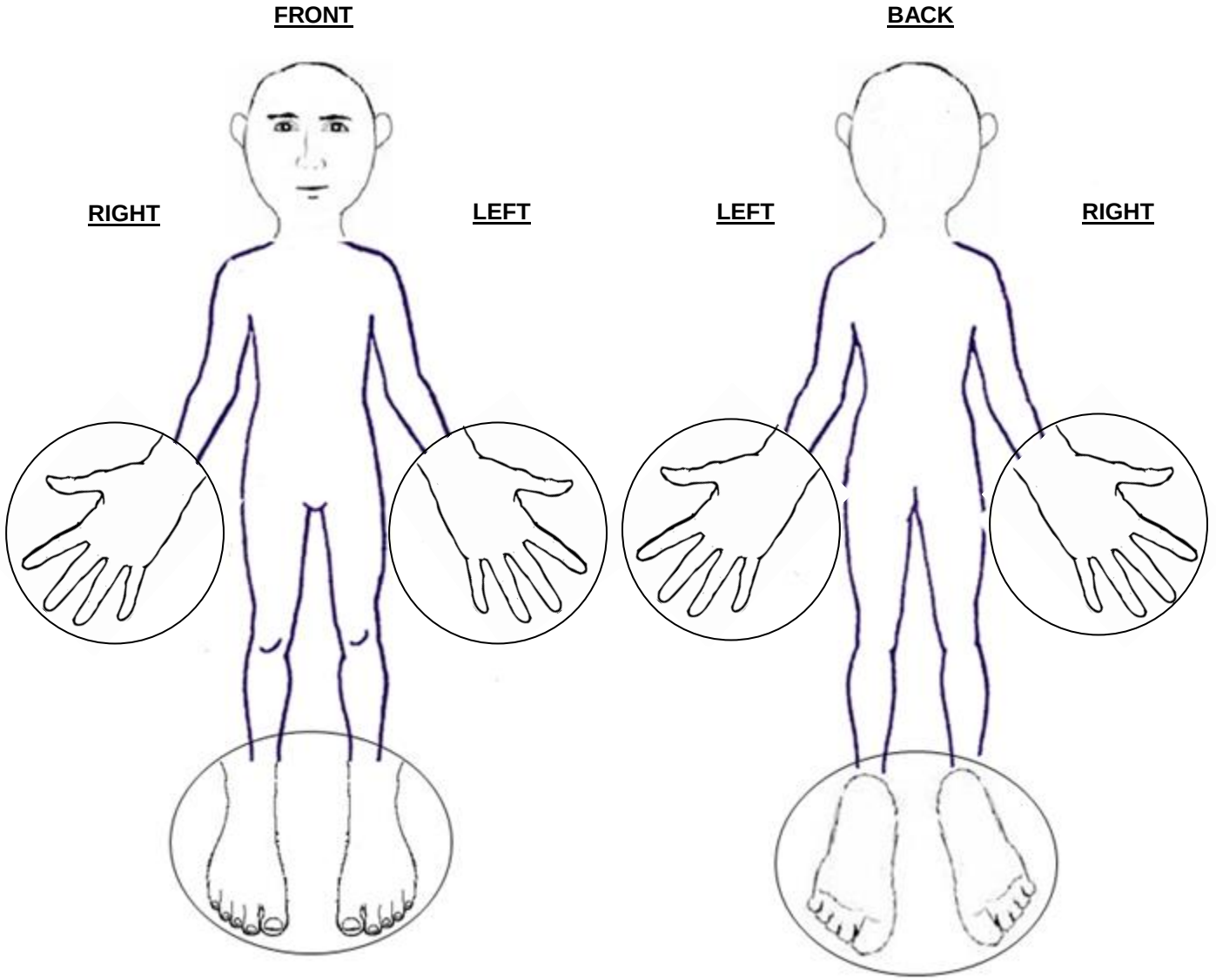
Any loss of work time due to this injury/illness must be certified by a Physician. Employee is required to provide the RCUH with a Physician's Certification of Disability.

20. IDENTIFY SPECIFIC BODY PART(S) INJURED. Describe the injury/illness and first aid administered by certified First Aider.: _____

_____

_____

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



PART B: **ACCIDENT INVESTIGATION (INCLUDE ATTACHMENTS):**

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, diagrams or other descriptive documentation 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.**

STATEMENT OF CERTIFICATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION *(This authorization allows my physician, hospital, clinic, or other medical institutionto release and allow RCUH and/or its insurance company access to information/documentation of treatments rendered to me for my injury/illness; includes results of accident or injury related testing, and as applicable prior medical history related to this injury/illness.) I understand any falsification of this information may result in disciplinary action including and up to termination of employment.*

_____ _____ _____
Employee Name | Employee Signature | Date

_____ _____ _____
Work Phone Number | Home/Cell Phone Number | E-mail Address

REVIEWED BY IMMEDIATE SUPERVISOR/SAFETY COORDINATOR AND PRINCIPAL INVESTIGATOR:

_____ _____ _____
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

_____ _____ _____
Principal Investigator Name | Principal Investigator Signature | Date

_____ _____ _____
Phone Number | Fax Number | E-mail Address

REMINDERS:
1. Any loss of work time due to this injury/illness must be certified by a Physician. Employee is required to provide the RCUH with a Physician's Certification of Disability. .
2. Complete and send this form in to the RCUH Director of Human Resources immediately viafax 808/956-9423, email rcuhhr@rcuh.com or mail original forms to John A Burns Hall 4th Floor Makai Wing, 1601 East West Road, Honolulu, HI 96822.
3. Scan and encrypt email photo(s) of the equipment, location/work environment, object that may have caused the injury/illness. 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 RCUH 3.580 Workers' Compensation policy.