



Supervisor's Report of Industrial Injury

CONFIDENTIAL

Upon completion of this report, please email it to RCUH HR (rcuh_benefits@rcuh.com) or fax to (808) 956-9423 within 24 hours of Injury/Illness/Accident. In cases of a catastrophic event (i.e., death, inpatient hospitalization, amputation, loss of an eye, or property damage in excess of \$25,000), please call RCUH HR immediately at (808) 956-2326 or (808) 956-6979.

(Part A and Part B **MUST** be completed)

1. EMPLOYEE'S NAME (Last, First, MI)		2. PROJECT NAME		3. CLASSIFICATION: <input type="checkbox"/> Regular <input type="checkbox"/> Student <input type="checkbox"/> Temporary <input type="checkbox"/> Volunteer	
4. EMPLOYEE'S RCUH ID#		5. EMPLOYEE'S ADDRESS (No., Street, City, State, Zip Code)		6. MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> 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					
<input type="checkbox"/> First Aid Only (i.e., employee was <u>not</u> referred to hospital or doctor). <input type="checkbox"/> Referred to hospital/doctor, current status unknown (provide medical note if treated) <input type="checkbox"/> 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

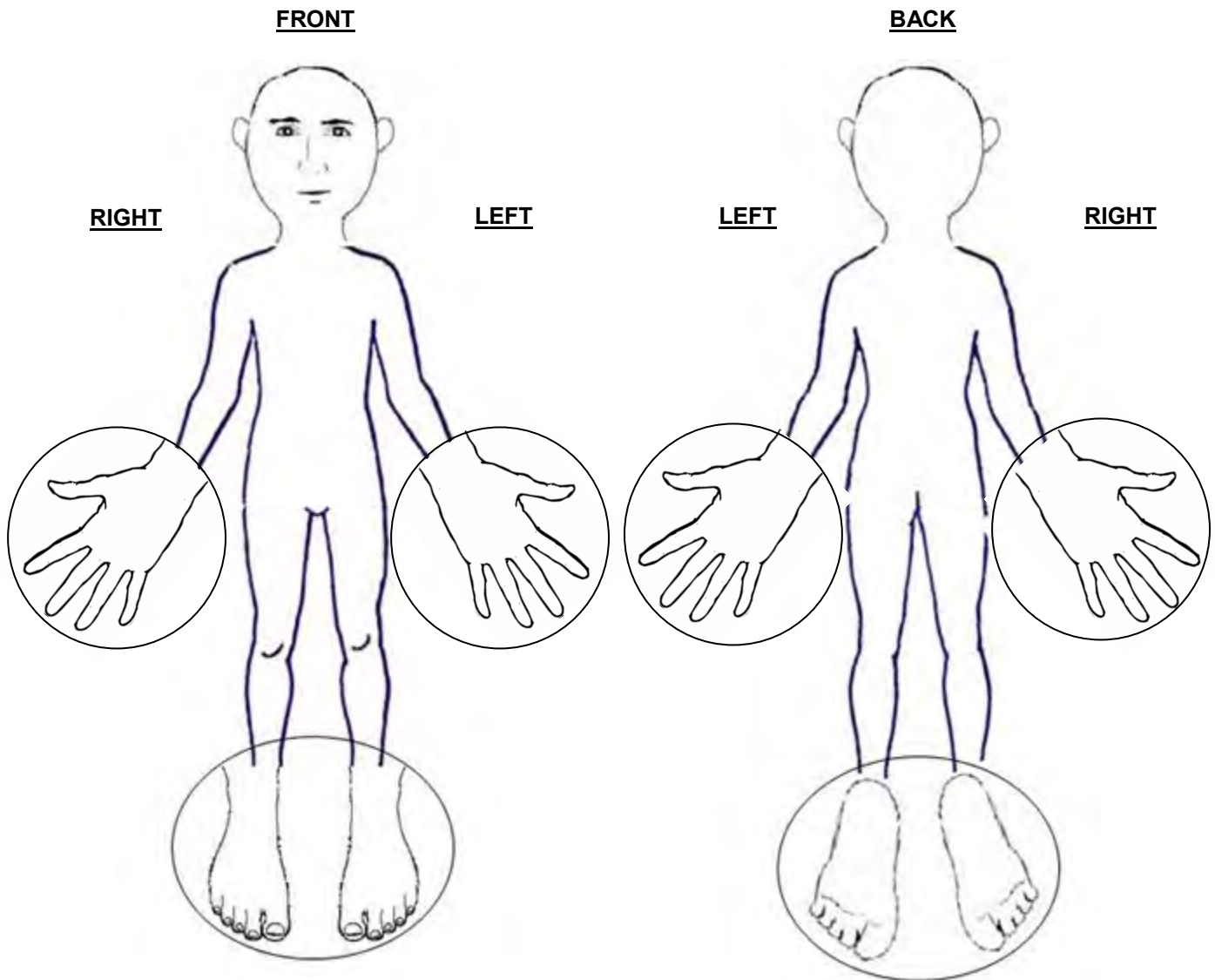
Has employee returned to work? Yes or No If "Yes", enter date returned: ____/____/____ (MM/DD/YY)

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 institution to 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. Scan and encrypt email photo(s) of the equipment, location/work environment, object that may have caused the injury/illness to rcuh_benefits@rcuh.com.
 3. Refer to RCUH 3.580 Workers' Compensation and 3.930 Safety and Accident Prevention Program policies for more information.
 4. Provide the Employee with the "Guidance for Work-Related Injury or Illness on or after July 1, 2020" located on RCUH 3.580 Workers' Compensation policy.