

## North Dakota State University Incident Reporting Responsibilities

Employee	Supervisor
<ol style="list-style-type: none"> <li>1. Report incident/event <b>immediately</b> to your supervisor</li> <li>2. Assess for first aid or medical treatment</li> <li>3. Complete the incident report immediately and fax to the Safety Office (<b>24 hour reporting requirement</b>)</li> <li>4. If you need medical care - report to NDSU's Designated Medical Provider</li> <li>5. Bring First Report of Injury Form from the Medical Provider to the Claims Specialist immediately</li> <li>6. Complete additional required Workers Comp forms with the Claims Specialist</li> <li>7. You are required to follow medical restriction 24/7</li> <li>8. You are required to accept modified work</li> <li>9. Keep the Claims Specialist informed of referrals, restrictions and medical visits</li> <li>10. Sign and date all documents</li> </ol>	<ol style="list-style-type: none"> <li>1. Assess the injury for first aid or medical treatment - if medical treatment is needed, send or take to the Designated Medical Provider</li> <li>2. Provide a copy of the Incident Report Form to the employee</li> <li>3. Assess the event/incident for immediate hazards and conduct an investigation</li> <li>4. Complete the Supervisor's portion of the Incident Report Form and fax to the Claims Specialist immediately</li> <li>5. Identify Corrective Actions to prevent similar incident from occurring again</li> <li>6. Repair, Replace, Remove or Retrain/Train</li> <li>7. Monitor the Return to Work and provide temporary accommodations for restrictions</li> <li>8. Work with the injured worker and Claims Specialist throughout the claims process</li> <li>9. Sign and date all documents</li> </ol>
<p><b>NDSU Claims Specialist: (701)231-6740</b>  <b>NDSU Safety Office Fax: (701)231-6739</b>  <b>NDSU Safety Office: (701)231-7759</b></p>	

## NDSU Report of Occupational Incident/Injury/Illness/Exposure

UNIVERSITY POLICY REQUIRES THAT AN OCCUPATIONAL INCIDENT/INJURY/ILLNESS/EXPOSURE BE REPORTED TO ND RISK MANAGEMENT WITHIN 24 HOURS OF OCCURRENCE AND STATE REGULATIONS REQUIRE THAT ALL EVENTS BE INVESTIGATED. Omission of information could result in a delay of benefits. This form must be FAXED to the Safety Office IMMEDIATELY or within 24 hours to 701-231-6739. If Medical attention is required, it is imperative that you contact the Claims Specialist IMMEDIATELY or within 24 hours at 701-231-6740.

**EMPLOYEE MUST COMPLETE THESE SECTIONS:**

EMPLOYEE DATA	Incident/Injury/Illness/Exposure Date: _____ Time: _____ AM <input type="checkbox"/> PM <input type="checkbox"/>		Employee Name: _____		Employee's ID #: _____	
	Address: _____				Home Phone: (____) _____	
	City/State/Zip: _____			Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth: _____
	Department/Location: _____			Employee's Work Phone: (____) _____		
	Job Title: _____		Annual Gross Salary: _____ \$		Date Supervisor Notified: _____	
	Supervisor's Name: _____			Supervisor's Work Phone: (____) _____		

EMPLOYEE STATEMENT	1. <b>Bodily Injury</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		2. Specific Injury/Illness/exposure: _____		3. Body Part(s) affected _____		Have you had prior injury to that body part? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Location where incident/injury/illness/exposure occurred (street, building, room, etc.) _____						Witness Name: _____	
	What equipment, materials or chemicals caused the incident/injury/illness/exposure: _____						Witness Phone #: _____	
	Explain in detail how the incident/event occurred. Include specific activities/tasks performed at the time. _____ _____ _____							
	Medical Treatment provided by: <input type="checkbox"/> Meritcare Occ Health <input type="checkbox"/> First Aid, no medical care needed      Date of First Medical Treatment: _____ <input type="checkbox"/> Innovis/Dakota Occ Health <input type="checkbox"/> Other: _____							
	Property Damage Yes <input type="checkbox"/> No <input type="checkbox"/>			Owner's Last Name: _____			First Name: _____	
	Owner's Street Address: _____		City: _____	State: _____	Zip: _____	Phone #: _____		
What was damaged? _____						Was state property damaged? Yes <input type="checkbox"/> No <input type="checkbox"/>		
*Employee Signature: (Fax this portion of the report IMMEDIATELY to 231-6739)						*Today's Date: _____		

SUPERVISOR'S INVESTIGATION AND STATEMENT (SUPERVISOR COMPLETES): (Fax immediately to 231- 6739)

EMPLOYER	After the investigation, explain in detail how the incident/injury/illness/exposure occurred and the specific activity being performed: _____ _____ _____	
	What was the incident, injury, illness or exposure? _____ _____	

1. INITIAL CAUSE	2. CONTRIBUTING FACTORS AND ACTIVITIES	3. PREVENTIVE ACTIONS	
<input type="checkbox"/> Struck by or against an object <input type="checkbox"/> Caught in/under/ between <input type="checkbox"/> Fall / Slip / Trip <input type="checkbox"/> Material handling or lifting <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Body fluid Exposure <input type="checkbox"/> Cut/Puncture <input type="checkbox"/> Fire <input type="checkbox"/> Animal bite <input type="checkbox"/> Other, Explain _____ _____ _____ _____	<b>Equipment</b> <input type="checkbox"/> Equipment failure <input type="checkbox"/> Improper equipment or material used for job <b>Personal protective equipment</b> <input type="checkbox"/> Not worn <input type="checkbox"/> Not readily available <input type="checkbox"/> Not adequate for the task <input type="checkbox"/> Personal protective equipment failure <b>Training/Experience</b> <input type="checkbox"/> Lack of training <input type="checkbox"/> Safety training provided, not followed <input type="checkbox"/> New task for employee or lack of experience <b>Work Area</b> <input type="checkbox"/> Work area set up improperly <input type="checkbox"/> Ergonomic factors <input type="checkbox"/> Sanitary & housekeeping issues <input type="checkbox"/> Lack of cord management	<b>Employee</b> <input type="checkbox"/> Employee fatigue <input type="checkbox"/> Unbalanced or poor position or motion <input type="checkbox"/> Not paying attention <input type="checkbox"/> Improper footwear for conditions <input type="checkbox"/> Going too fast <input type="checkbox"/> Taking short cuts <input type="checkbox"/> Not aware of surroundings <input type="checkbox"/> Not reporting in a timely manner <input type="checkbox"/> Lack of policy/procedure <input type="checkbox"/> Poor housekeeping practices <input type="checkbox"/> Improper behavior and attitude <input type="checkbox"/> Disregard for safety rules <input type="checkbox"/> Animal (explain below) <input type="checkbox"/> <b>Other unsafe practice(explain)</b> _____ _____ _____ <input type="checkbox"/> <b>Environmental factors</b> (circle) (clear, rain, snow, sleet, hail, etc)	<b>SUPERVISOR: (must be completed)</b> <input type="checkbox"/> Develop/revise safety policies/procedures And/or update plan <input type="checkbox"/> Request ergonomic evaluation <input type="checkbox"/> Require personal protective equipment <input type="checkbox"/> Remove equipment from use and repair or replace <input type="checkbox"/> Schedule preventive maintenance <input type="checkbox"/> Retrain employee in proper procedures <input type="checkbox"/> Require Baseline Safety Training <input type="checkbox"/> Inform employee to slow down <input type="checkbox"/> Address behavior and attitude <input type="checkbox"/> Address employee work practices <input type="checkbox"/> Maintain housekeeping and sanitary conditions <input type="checkbox"/> <b>Work Order completed</b> <input type="checkbox"/> Contact Facilities Management (ice, etc.) <input type="checkbox"/> Other: Please explain _____ <b>Complete 1,2 &amp; 3</b> <b>Use additional pages as needed</b>

SUPERVISOR'S OR MANAGER'S SIGNATURE: _____	Date of Investigation: _____
NDSU CLAIMS MANAGEMENT SPECIALIST: _____	Date Received: _____