# North Dakota State University

## Incident Reporting Responsibilities

<table>
<thead>
<tr>
<th>Employee</th>
<th>Supervisor</th>
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<tbody>
<tr>
<td>1. Report incident/event <strong>immediately</strong> to your supervisor</td>
<td>1. Assess the injury for first aid or medical treatment - if medical treatment is needed, send or take to the Designated Medical Provider</td>
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<tr>
<td>2. Assess for first aid or medical treatment</td>
<td>2. Provide a copy of the Incident Report Form to the employee</td>
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<td>3. Complete the incident report immediately and fax to the Safety Office (24 hour reporting requirement)</td>
<td>3. Assess the event/incident for immediate hazards and conduct an investigation</td>
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<td>4. If you need medical care - report to NDSU’s Designated Medical Provider</td>
<td>4. Complete the Supervisor’s portion of the Incident Report Form and fax to the Claims Specialist immediately</td>
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<tr>
<td>5. Bring First Report of Injury Form from the Medical Provider to the Claims Specialist immediately</td>
<td>5. Identify Corrective Actions to prevent similar incident from occurring again</td>
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<td>6. Complete additional required Workers Comp forms with the Claims Specialist</td>
<td>6. Repair, Replace, Remove or Retrain/Train</td>
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<td>7. You are required to follow medical restriction 24/7</td>
<td>7. Monitor the Return to Work and provide temporary accommodations for restrictions</td>
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<tr>
<td>8. You are required to accept modified work</td>
<td>8. Work with the injured worker and Claims Specialist throughout the claims process</td>
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<tr>
<td>9. Keep the Claims Specialist informed of referrals, restrictions and medical visits</td>
<td>9. Sign and date all documents</td>
</tr>
<tr>
<td>10. Sign and date all documents</td>
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</tr>
</tbody>
</table>

**NDSU Claims Specialist**: (701)231-6740  
**NDSU Safety Office Fax**: (701)231-6739  
**NDSU Safety Office**: (701)231-7759

North Dakota State University does not discriminate on the basis of race, color, national origin, religion, sex, gender identity, disability, age, status as a U.S. veteran, sexual orientation, marital status, or public assistance status. Direct inquiries to the Vice President for Equity, Diversity and Global Outreach, 205 Old Main, (701)231-7708.
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:**

### Incident/Injury/Illness/Exposure Data
- **Date:** __________________
- **Time:** AM □ PM □
- **Employee Name:** __________________
- **Employee’s ID #:** __________________
- **Address:** __________________
- **City/State/Zip:** __________________
- **Sex:** □ Female □ Male
- **Date of Birth:** __________________
- **Department/Location:** __________________
- **Employee’s Work Phone:** ( ______ )
- **Job Title:** __________________
- **Annual Gross Salary:** __________________
- **Date Supervisor Notified:** __________________

### Employee’s Information
- **Home Phone:** ( ______ )
- **Date Supervisor Notified:** __________________

### Employee’s Statement
- **Medical Treatment provided by:**
  - Sanford Clinic Occ Medicine □
  - Essentia Occ Health □
  - Other □
- **First Aid, no medical care needed □
- **Date of First Medical Treatment:** ________________

### Property Damage
- **Yes □ No □
- **Owner's Last Name:** __________________
- **Owner's First Name:** __________________
- **Owner's Street Address:** __________________
- **City:** __________________
- **State:** __________________
- **Zip:** __________________
- **Phone #:** __________________
- **What was damaged?** __________________
- **Was state property damaged?** □ Yes □ No □

### EMPLOYEE STATEMENT
- **Medical Treatment provided by:**
  - Sanford Clinic Occ Medicine □
  - Essentia Occ Health □
  - Other □
- **First Aid, no medical care needed □
- **Date of First Medical Treatment:** ________________

### Supervisor’s Investigation and Statement (Supervisor Completes)
- **After the investigation, explain in detail how the incident/injury/illness/exposure occurred and the specific activity being performed:**

### Supervisor’s or Manager’s Signature
- **Date of Investigation:** __________________

### NDSU Claims Management Specialist
- **Date Received:** __________________