Employee's Report of Work-Related Injury
University of Maryland, College Park

To be completed immediately after the accident or initial treatment and submitted to your supervisor.

Employee Name (first, last)	UID	Gender ☐ M ☐ F	Date of birth	Marital status ☐ Married ☐ Unmarried	# of dependent children

Home Address		Phone #	Employment status (check one)
City	State	Zip Code	☐ Contingent I ☐ Contingent II ☐ Hourly ☐ Faculty ☐ Non-exempt FT/PT ☐ Exempt FT/PT ☐ Research/ Grad Assistant

Job title	Employment start date	Time workday began	
Department	Work phone #	Gross wages (biweekly)	

Date of accident	Time	Location - Building	Area (hallway, office, etc)

Describe in detail how the accident occurred. Describe the work-process you were engaged in, give the purpose of the function or task, describe how the injury occurred, and explain the cause.

Part of body injured. Be specific - example: right middle finger, left ankle, upper back.	Type of injury. Example - sprain, burn (degree of burn), contusion, sutured

Was medical treatment sought? ☐ Yes ☐ No	If so, name of medical provider	Medical provider phone #	# of days worked with restrictions

# of days missed from work	Return to work date (as stated by physician)	Type of leave used	Was safety equipment provided? ☐ Yes ☐ No	Was safety equipment used? ☐ Yes ☐ No

Supervisor's name	Supervisor phone #	Date accident reported to supervisor
Name of witness(es)	Witness phone #	

Not valid unless signed. By signing this form, I acknowledge that all statements made herein are true and correct to the best of my knowledge.

Signature of employee	Date

Employee Instructions for a Work-Related Injury

University of Maryland, College Park

The following information is provided to guide the employee who is injured while at work. It is important that these instructions be followed in order to receive all available benefits.

If possible, provide a verbal description of the accident to your supervisor, immediately after the accident.

Medical Treatment:

Injured while on campus:

If you are injured while working on campus and need medical attention, it is recommended that you go to the Health Center. The Health Center will provide you with all the necessary forms to report the accident. Provide your immediate supervisor with the Supervisor's Report of Work-Related Injury form for completion and your completed Employee's Report of Work-Related Injury form.

Note: **University Health Center Hours of Operation:** Monday - Friday 8:00am - 5:00pm | Saturday 9:00am - 12:00pm | Sunday CLOSED | LIMITED SERVICES ARE AVAILABLE UNTIL FURTHER NOTICE
HEAL Line: (301) 405-4325 (HEAL) | **Appointments:**(301) 314-8184 | **After-Hours Nurse Line:** (877) 924-7758 | **TELEMEDICINE : https://health.umd.edu/telemedicine | Emergency?** Call 911 or an Urgent Care Center

Injured while off-campus:

If you are injured while working off-campus and require immediate medical care from a nearby urgent care center, emergency room, or see your private physician, the accident report forms still need to be completed and are avail-able on the ESSR web site:

http://www.essr.umd.edu/ - click on Risk Management/Workers' Compensation and then click into the desired forms format.

Immediately following your initial treatment complete the accident report form and forward it to your supervisor.

IMPORTANT: Any medical treatment other than emergency visits, initial treatments, or routine office visits must be pre-authorized. Your medical provider will ask you for a "claim number" and insurance information. Once you have completed and submitted the accident report form, call the Workers' Compensation office @ (301) 405-5466 to obtain this number and information.

The Injured Workers' Insurance Fund (IWIF), a division of Chesapeake Employers Insurance Company is the workers' compensation insurance carrier for University employees. The IWIF adjuster may call you to investigate the incident. Provide as many details about the accident as you can. It will aid the adjuster in determining whether your injury is compensable under the Maryland Workers' Compensation Law.

- ***Note: If you do not complete and submit the injury report, the Health Center will bill you for services rendered.***
- ***You must provide your supervisor with a note from your doctor for any time off due to a job injury disability - regardless of what type of leave you are using.***

Supervisor's Report of Work-Related Injury
University of Maryland, College Park

To be completed by the supervisor or higher authority and submitted with all other reports to Workers' Compensation, Environmental Safety, Seneca Bldg. 4716 Pontiac St. within 24 hours.

To be completed by ESSR/WC) (Claim) IWIF#	Name of injured employee			
Date of accident	**Date Employer/Supervisor was notified**	**Time of accident**	**Location - Building**	**Area (hallway, office, etc)**

Describe in detail how the accident occurred. Describe the work-process you were engaged in, give the purpose of the function or task, describe how the injury occurred, and explain the cause.

Part of body injured. Be specific - example: right middle finger, left ankle, upper back.	**Type of injury.** Example - sprain, burn (degree of burn), contusion, sutured

Return to work date (as stated by physician)	**# of days missed from work**	**Type of leave used**	**# of days worked with restrictions**

Name of witness(es)	**Witness job title**	**Witness phone #**

Do you agree with the employee's description of the accident? ☐ Yes ☐ No
If no, please explain:

Was safety equipment provided? ☐ Yes ☐ No	**Was safety equipment used?** ☐ Yes ☐ No	**If no, explain:**

Recommendation on how to prevent this accident from recurring:

Supervisor's name/department	**Work phone #**

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Signature of supervisor	**Date**

Supervisor Instructions for Reporting a Work-Related Injury
University of Maryland, College Park

Get as many details as possible about the incident from the employee and witness(es).

Collect the completed Employee's Report of Work-Related Injury Form and Accident Witness Statement. Complete the Supervisor's Report of Work-Related Injury Form and return all forms within 24 hours to:

Email/Deliver to:
Your Department's HR Workers' Compensation Designee (if you don't have a Designee)

Email to:
workerscomp@umd.edu

or

Deliver to:
Workers' Compensation
Department of Environmental Safety, Sustainability, and Risk (ESSR)
Seneca Bldg., 4716 Pontiac St. Suite 0103

Report the number of days lost from work and/or the number of days employee is working with restrictions. If the information is not available at the time of completing the report, call the Workers' Compensation Office (301) 405-5466 when the employee returns to work or is no longer working with restrictions.

When an employee is absent due to a job injury, the supervisor must require medical documentation for this disability. If long term, disability notes are required every two weeks. This medical documentation should contain:

- a diagnosis
- current medical management restrictions
- a return to work date

If the employee is returned to work in a modified duty capacity, the supervisor should make every effort to accommodate the restrictions. University policy states that an employee is eligible for accident leave immediately for up to 30 days unless otherwise notified. Only employees in "permanent employment" status are eligible for accident leave.

Any questions call (301) 405-5466.

Accident Witness Statement
University of Maryland, College Park

To be completed within 24 hours of the accident.

Name of injured employee				
Department	**Date of accident**	**Time of accident**	**Location - Building**	**Area (hallway, office, etc)**
Describe in detail how the accident occurred. Describe what employee was doing, how the accident occured, and what caused it.				
Part of body injured. Please be specific - example: right middle finger, left ankle, upper back.				
Was safety equipment provided? ☑ Yes ■ No	**Was safety equipment used?** ☑ Yes ☑ No	**If no, explain:**		
Recommendation on how to prevent this accident from recurring:				
Name of witness	**Work phone #**	**Cell phone #**		
Not valid unless signed. By signing this form, I acknowledge that all statements made herein are true and correct to the best of my knowledge.				
Signature of witness	**Date**			