PROCEDURES FOR FILING A WORKER’S COMPENSATION CLAIM

Any time an employee is injured on the job, an Accident Report form must be completed. Please follow the instructions below when a work related injury occurs.

- Employee reports the accident to his or her supervisor. If the direct supervisor is not on duty, follow the normal chain of command (i.e., Supervisor, Director, Dean, etc.). Follow-up with supervisor at the next available opportunity.

- If immediate medical attention is needed, please go to the nearest Emergency Room. If the injury is not serious and needing immediate attention, please contact the Human Resource Department and we will set up an appointment for you with our worker’s compensation physician.

- All accidents should be reported within (A) 20 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 10 calendar days after the employee’s last day of actual work for the employer. If the accident is not reported within this time frame, the claim could be denied by the insurance provider.

- The Accident Report form is completed by the Supervisor with help from the employee. The Report by Injured Employee is completed by the employee. If there are witnesses to the accident, the witnesses must complete the Report By Eyewitness form.

- The Accident Report form must be forwarded for signature and comments to the Department Head or Dean. All forms are then submitted to Human Resources.

- Once Human Resources has received the forms, an Employer’s Report of Accident will be filed with the insurance company.

- All correspondence (work status forms, work releases, work restrictions, etc.) should be submitted to the supervisor. The originals will need to be forwarded to Human Resources.

- Any and all bills for medical treatments, prescriptions, etc., need to be given to Human Resources to be submitted for reimbursement.

- If questions arise, please contact the Employment/Benefits Specialist at extension 6768.

(Revised 5/13)
Accident Report
For Work Related Injury
Butler Community College

I. Employee Name
   First
   M.I.
   Last
   SS#__________________________ Male_______ Female_____
   Home Phone_________________ Date of Birth______________
   Address____________________ Street City Zip
   Occupation____________________

II. Time of accident_____________ am/pm Date of accident______________
   Location of accident______________ On school property? Yes____ No____
   Exactly how did accident occur (Describe persons, actions, equipment conditions involved):
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   Describe weather conditions (if applicable):________________________
   Was accident site reviewed by the Supervisor? Yes______ No______
   How could this accident have been prevented? (better training, policy, etc)__________
   What immediate action has been taken to prevent the recurrence of a similar accident?____

Parts of body injured (circle Right or Left where applicable):
☐ Head ☐ Neck ☐ Wrist R L
☐ Eye R L ☐ Chest ☐ Hand R L
☐ Ear R L ☐ Shoulder R L ☐ Finger R L
☐ Nose ☐ Arm R L ☐ Abdomen
☐ Mouth ☐ Elbow R L ☐ Groin
☐ Back ☐ Ankle R L ☐ Hip R L
☐ Foot R L ☐ Thigh R L ☐ Knee R L
☐ Other________________________


III. Medical Data (treatment disposition)
   □ No treatment
   □ Received first aid. Administered by:__________________________
   □ Received medical attention. ***Complete questions below.
   □ Lost time. _________ Days.
   □ Died

   **Physician/Hospital taken/went to: ________________________________
   **By whom? ________________________________________________
   **Address of Physician/Hospital __________________________________________

   Will employee lose time from work?   Yes______   No______
   Was employee wearing/using required safety equipment? Yes____ No____ NA____

   Hours into shift when accident occurred?______________________________
   How long has employee been employed?______________________________
   Did accident occur as part of an extra curricular or special event? Yes____ No____

   Report By Injured Employee attached?   Yes______   No______
   Report By Eyewitness attached?       Yes______   No______

   Additional Comments:______________________________________________
   _______________________________________________________________

   Supervisor’s Signature_________________________   Date______________
   ________________________________ (please print)

TO BE COMPLETED BY DEPARTMENT HEAD:

Comments:________________________________________________________
   _______________________________________________________________

Report Reviewed By_________________________   Date______________

(Revised 8/05)
**Report by Injured Employee**  
*Butler Community College*

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<th><strong>Name</strong></th>
<th><strong>Date</strong></th>
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<th><strong>Age</strong></th>
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<tr>
<th><strong>Date of Injury</strong></th>
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<th><strong>Date Reported</strong></th>
<th><strong>Supervisor’s Name</strong></th>
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**In your own words, describe what happened**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**What problems do you relate to this injury**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Were you working at your regular job at the time of injury?**  
Yes______  No______  
If no, please explain__________________________________________

**Were there any witnesses?**  Yes____  No____  If yes, who?_____________________

**Additional comments**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Employee Signature**  
_________________________________________  **Date**______


Report By Eyewitness
Butler Community College

Name of Injured Employee

Name of Witness

Witness Address

Street City Zip

Witness Phone Number

In your own words, describe what you saw happen


Did anyone else see the accident? Yes No
If yes, who?

Other comments


Signature of Witness Date