



# ***How to Handle Workplace Injuries***

Goodwin College strives to provide a safe, healthy work environment for all faculty and staff. However, accidents can and do sometimes happen. This policy outlines the steps that faculty and staff should follow in the event of an on-site injury.

## **Responsibilities of the Injured Employee**

1. Give notice to your direct supervisor and Human Resources immediately after the incident (***within 24 hours***).
2. Request that an in-house "Incident Report" be completed.
3. Request information on obtaining medical care.
4. Complete a 1st Report of Injury (**located on the Goodwin website:** ) and forward to Human Resources, along with the Incident Report.

## **Responsibilities of the Direct Supervisor**

1. The direct supervisor is responsible for assessing the incident (emergency or non-emergency). They are then responsible for documenting, with the assistance of the injured employee, the facts of the accident/injury. If the injured employee is too upset to give an accounting, then the direct supervisor, along with another co-worker should work together to soothe and collect the information from the injured employee, as well as look to witnesses to help fill in the facts. All efforts should be made to get an accurate accounting of the injury and the circumstances that led to the injury prior to the injured employee leaving the premises of the accident/injury site. The injured employee should be requested to acknowledge the facts by signing and dating the incident report, if possible. Statements and signatures should be acquired from any witnesses to the accident.
2. If the injury is determined to be a non-emergency, the direct supervisor shall present the employee with the name and contact information for the College's suggested Health Service Provider for continued treatment..
3. If the injury is determined to be an emergency, the direct supervisor is to get the necessary medical treatment for the injured employee by calling **911**. Once the emergency has been addressed, it is the responsibility of the direct supervisor to ascertain the facts. The direct supervisor should do this by talking to co-workers and witnesses to the accident/injury. If possible, information should be gathered from any EMT personnel, if they were called. The Occupational Health Service Provider information should then be given over the phone to the injured employee and/or by direct mail. A signed copy of the incident report should be sent to the injured employee by certified mail for his/her records.

***Once the facts have been collected, the direct supervisor shall forward the "1st Report of Injury" and the "Incident Report" to Human Resources.***

### INCIDENT REPORT

This form must be completed within 24 hours of an incident and submitted to the Department Chair reporting all injuries and exposures.

#### /Employee Information

**Name:**

**Subject:**

**Supervisor's Name**

**Supervisor's Extension**

#### Incident Information

**Date of Injury:**

**Time of Injury:**

**Name of Injured:**

*(include phone number)*

**Physical Location Where**

**Injury Occurred:** *(Clearly*

*state which classroom incident*

*occurred in)*

#### Narrative of Incident

Please describe details of incident and include any witnesses including their phone number.

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Was employee wearing issued Personal Protective Equipment (PPE)?

Yes     No     NA

Was employee or their clothes contaminated by any substance?

Yes     No

If yes, please describe

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**INCIDENT REPORT**

Employee Name:

**Type of Medical Attention**

Did employee remain at work?

Yes     No

Did employee receive First Aid at work?

Yes     No

Was employee referred to Physician or Occupational Medicine?

Yes     No

Was employee transported to an emergency facility?

Yes     No

If yes, please describe type of transportation (private vehicle, ambulance, etc.)

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Were any other agencies involved in incident/injury (Fire Department, EMS, Police, etc.)?

Yes     No

If yes, please describe

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**Recommendations to Prevent This Type of Incident In The Future**

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Employee's Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Employee's Supervisor's Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

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# WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GOODW-3

OP ID DD

EMPLOYER (NAME & ADDRESS INCL ZIP) Goodwin College, Inc. One Riverside Drive East Hartford CT 06118		CARRIER/ADMINISTRATOR CLAIM NUMBER *		REPORT PURPOSE CODE *	
INDUSTRY CODE		EMPLOYER FEIN 06-1627882		PHONE # 528-4111	
JURISDICTION *		JURISDICTION CLAIM NUMBER *		OSHA CASE NUMBER	
INSURED REPORT NUMBER		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #:	

## CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO) Utica National Ins Group 180 Genesee Street New Hartford NY 13413		POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)		
CARRIER FEIN *		POLICY/SELF-INSURED NUMBER 4071009	ADMINISTRATOR FEIN *		
AGENT NAME & CODE NUMBER		CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE			

## EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE	
PHONE		# OF DEPENDENTS	EMPLOYMENT STATUS		NCCI CLASS CODE *
RATE PER:	DAY	MONTH	AVERAGE WEEKLY WAGES	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?
WEEK	OTHER:				YES NO YES NO

## OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE *		PART OF BODY AFFECTED CODE *		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.							CAUSE OF INJURY CODE *
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		YES NO	YES NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> OVERNIGHT HOSPITALIZATION <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
WITNESSES (NAME & PHONE #)			PHONE NUMBER				
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE					