How to Handle Workplace Injuries

Goodwin University 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.

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

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.)

Were any other agencies involved in incident/injury (Fire Department, EMS, Police, etc.)?
☐ Yes ☐ No

If yes, please describe

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

ACORD® WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

GOODW-3 OP ID DD

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

CARRIER/CLAIMS ADMINISTRATOR

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

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE *	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ 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? ☐ YES ☐ 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? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
		☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ OVERNIGHT HOSPITALIZATION ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED
WITNESSES (NAME & PHONE #)		

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE