Employee's Responsibilities in the event of the work-related injury or illness of an employee:

- Report all accidents and injuries to your supervisor immediately.
- If medically possible, you will be taken or sent to the nearest medical provider
  
  Pine Ridge Urgent Care and Occupational Medicine  
  Center 1413 Greenway Court  
  Sanford, NC 27330  
  919-775-3020

- **OR** you may contact the WC Administrator (WCA) for a listing of authorized physicians from which you may choose.

- **In life-threatening emergencies, you will be taken to the nearest medical facility**

- If possible, you will be given a medical authorization form to give to the medical provider. This will ensure that the bill for the treatment will go to the third party administrator, Corvel, for payment.

- As soon as possible after medical treatment, you will be asked to complete an Employee Statement and Leave Option Form. The completed form must be given to your supervisor or the WCA as soon as possible.
  
  Provide a doctor’s note to your supervisor or the WCA stating any medical restrictions placed on you as a result of the injury.

- Adhere to any transitional duty assigned to you as part of the CCCC Return to Work Program.

CCCC WC Administrator(s) | Daisha Gaines [919-718-7213]  
Joseph Henderson [919-718-7291]

CCCC Safety Coordinator | Ben Rankin [919-718-7309]
CENTRAL CAROLINA COMMUNITY COLLEGE
WORKER’S COMPENSATION (WC) PROGRAM

**Supervisor's Responsibilities** in the event of the work-related injury or illness of an employee:

- Correct unsafe conditions immediately
- Ensure immediate and appropriate medical care for the employee. In life-threatening emergencies, get the employee to the nearest medical facility.
- If medically possible, send the employee to Pine Ridge Urgent Care and Occupational Medicine
  Center 1413 Greenway Court
  Sanford, NC 27330
  919-775-3020

**OR** contact the WC Administrator (WCA) for a listing of authorized physicians to which the employee may be directed.

- Provide the employee with an *Employee’s Responsibilities form, Medical Authorization form, Initial Treatment Guide, NC Industrial Commission FORM 18 "Notice of Accident to Employer and Claim of Employee, Representative, or Dependent”, and Physician’s Report* (attached).
- Complete the *NC Industrial Commission FORM 19 "Employer's Report of Injury or Occupational Disease to the Industrial Commission"* (attached). Complete the form in as much detail as possible and give it to the WCA within 24 hours of the accident or report of illness.
- Assist in the accident investigation by completing the *Supervisor’s Accident/Incident Investigation Report* (attached) and give it to the WCA.
- As soon as possible after medical treatment, provide the employee with an *Employee Statement and Leave Option Form* (attached) for completion. The statement must be given to the WCA as soon as possible after the accident or report of illness.
- Communicate with the injured employee to ensure that their needs are met. Immediately upon receipt of any information regarding lost work time or returning to work, notify the WCA.

CCCC WC Administrator(s)  
Daisha Gaines [919-718-7213]  
Joseph Henderson [919-718-7291]

CCCC Safety Coordinator  
Ben Rankin [919-718-7309]
AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I, the undersigned, authorize any physician, physician's assistant or nurse who has attended me, or any hospital at which I have been confined, to furnish to any authorized representative of CORVEL CORPORATION, any and all information which may be requested regarding my condition and/or treatment, and to allow them to examine and copy any radiographic pictures taken of me, or records regarding my condition or treatment. I specifically authorize said physicians, nurses and hospitals to communicate information by any reasonable means, including written or telephonic communication or by direct interview, whether or not I am present during or notified of such communications, and I authorize, to initiate and conduct such communications whether or not I am present or have notice thereof.

A photostatic or faxed copy of this waiver is to be given the same force and effect as the original.

Signature: __________________________
Address: ____________________________
Social Security #: ______________________
Date of Birth: _________________________
Date: ________________________________
Printed Name Here ____________________

Witness ____________________________
EMPLOYER: Give both pages of this document to the injured employee to provide to the authorized treating physician.

Employer/Company: State of North Carolina - EC

EMPLOYEE: The following provider/facility was an available provider selected from CorVel’s provider network. It is your responsibility to contact a provider to schedule an appointment and to confirm the location.

Employee name: Record ID:
Date of injury:Treating provider/facility:

INITIAL TREATMENT PROVIDER/FACILITY:
Provider/Facility Name
Address
Call to schedule an appointment

Appointment Details
Date: __________________________
Time:

Disclaimer: The provider/facility listed above is provided for informational purposes only and is not intended to require the employee to seek medical treatment with the provider/facility listed. The rights of the employee in choosing a provider/facility vary state by state and each state law and/or statute supersedes any information implicitly or explicitly stated on this guide.

PHARMACY: Process all prescriptions online through CorVel’s pharmacy program for this patient and DO NOT charge the patient for the prescription. Call CorVel at (800) 563-8438 (8am — 11pm, M-F) for additional assistance. The Member ID is 9 digit social security number plus 8 digit date of injury.

PARTICIPATING PHARMACIES*

CostCo Pharmacy
CVS
Dominick’s Finer Foods
Fred’s Inc
Giant Eagle Pharmacy
Giant Food Stores LLC
H E Butt Drug Stores
Hy-Vee Inc
Kroger Pharmacy
Meijer Pharmacies
Publix Pharmacies
Rite Aid Pharmacy
Shoprite Supermarkets Inc
Smith’s Food & Drug Centers
Stop & Shop Supermarket Co
Target Pharmacy
Walgreens Pharmacy
Wal-Mart Pharmacy
Winn-Dixie Pharmacies

*This is only a partial list of the over 70,000 participating pharmacies in the CorVel Network. Please call (800) 563-8438 for additional locations.

Rev. Nov 2012
EMPLOYEE: Take this form with you and have the treating physician complete the Physician section below.

Employee name: Record ID:
Date of injury: Physician/facility:

PHYSICIAN: For compliance, please complete this section and email to RTW@onlinecapturecenter.com or fax to (800) 391-4320. This document authorizes initial evaluation and treatment only, and payment for these services will be rendered without prejudice.

DIAGNOSIS: ____________________________________

A post-accident drug test (check one): ☐ has been completed ☐ has not been completed

RESTRICTIONS: ____________________________________

In accordance with this patient's physical capability, check all that apply:

☐ May resume work immediately, no restrictions.

☐ May resume work immediately, with the following restrictions:
  ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
  ☐ Light work (lifting less than 20 pounds) ☐ Medium work (lifting less than 50 pounds)
  ☐ Limited hours: hours per day _______ ☐ Limited days: ____________ days per week
  ☐ Other: ____________________________________

☐ Repetitive motion restrictions (specific to hand/arm injuries):

FREQUENCY No Use Occasional Frequent Constant
LEFT
RIGHT

☐ Patient is unable to return to work in any capacity.

RETURN TO WORK/MMI/NEXT APPOINTMENT:

Date patient may return to work at full duty: __________________________

Projected date of attainment of Maximum Medical Improvement: ________________

Patient has a return appointment on (date): ___________ at (time): ______ AM / PM

ANCILLARY SERVICES:

Please call (866) 866-1101 if patient requires Physical Therapy, Imaging, DME, Transportation or Translation services.

Physician Name: _____________________________________ Date: ______________

Physician Signature: ____________________________________

Rev. Nov 2012
North Carolina Industrial Commission

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law. This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed Form 18 and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4334 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The use of this form is required under the provisions of the Workers' Compensation Act.
IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee’s representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACION IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesion (Reporting an Injury)

Si usted no este de acuerdo con la description o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesiOn por escrito y darselo a su empleador dentro de un periodo de treinta (30) dies a partir de la fecha de la lesiOn.

Como Presentar una Reclamacion (Making a Claim)

Para ceriorarse de que ha presentado una reclamacion, complete el Formulario 18 Notification de Accidents dentro de un periodo de dos arms a partir de la fecha de la lesion y envie una copia a la Comisi6n Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligaciOn que tiene el empleado de presentar una reclamacion. El empleado debe presentar el Formulario 18 aunque el empleador este pagando compensation sin tener un acuerdo o si la ComisiOn ha creado un expediente con respecto a esta reclamacion. Tambien se puede presentar una reclamacion por medio de una carta explicando la fecha y la naturaleza de la lesiOn o la enfermedad ocupacional. Este carte se debe firmar y envier a la Comisi6n Industrial asi como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISION INDUSTRIAL USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVIE A LA COMISION INDUSTRIAL POR FAVOR ESCRIBA EL NUMERO DE CASO DESIGNADO POR LA COMISION [LC. FILE NUMBER] (SI LO SABE) 0 SU NUMERO DE SEGURO SOCIAL.
**NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)**

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

<table>
<thead>
<tr>
<th>Employee’s Name</th>
<th>Employer’s Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Home Telephone</td>
<td>Employer’s Address</td>
<td>City</td>
</tr>
<tr>
<td>Work Telephone</td>
<td>Insurance Carrier</td>
<td>Policy Number</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>Sex</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

**EMPLOYEE** – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: __________ on ______/____/____ at __________. Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) __________________________

Describe how the injury or occupational disease occurred: ____________________________________________________________

Occupation when injured: ____________________ Nature of employer’s business: ____________________

Number of days out of work due to injury: ________

Medical treatment received? Yes No

Weekly wage: $ __________ Number of hours worked per day: __________ Days worked per week: __________

**NOTE:** If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

<table>
<thead>
<tr>
<th>Signature of (Check One)</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee, Attorney,</td>
<td></td>
</tr>
<tr>
<td>Representative, or Dependent</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Date Completed</td>
<td>Date</td>
</tr>
</tbody>
</table>

**EMPLOYER:** This notice is being sent to you in compliance with requirements of the North Carolina Workers’ Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

**MAIL TO:**

NCIC - CLAIMS ADMINISTRATION  
4335 MAIL SERVICE CENTER  
RALEIGH, NORTH CAROLINA 27699-4335  
MAIN TELEPHONE: (919) 807-2500  
HELPLINE: (800) 688-8349  
WEBSITE: HTTP://WWW.IC.NC.GOV/
GENERAL INFORMATION ON THE FORM 18

1. **What does Form 18 do?**

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $2,000.00. However, the employer’s filing of a Form 19 does not satisfy the employee’s obligation to file a claim. In order to ensure the employee’s rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. **To whom should the Form 18 be sent?**

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. **What numbers do I write in the upper right corner?**

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the “I.C. File No.” space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other three spaces, “Emp. Code No.,” “Carrier Code No.,” and “Employer FEIN” are for internal use only.

4. **What if I do not know who my employer’s insurance carrier is?**

If you do not know who the employer’s insurance carrier is you may either ask your employer for the information, call the Industrial Commission’s Claims Administration Section at (800) 688-8349 then press “1” after the prompt, or simply leave the line blank.

5. **When listing the number of days out of work, do I count partial days?**

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. **What happens after I file the Form 18?**

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers’ compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.
CC
cC

SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION REPORT

Name of Injured Employee: ________________________________
DOB: ____________________________________________
Sex: Male    Female
Social Security Number: ________________________________
Phone (H): ___________________________ Phone (W): ___________________________
Date of Hire: ___________________________  Home Address:
Work Address: ________________________________________

Time Employee began work: ___________________________
Occurred: ___________________________
Reported: ___________________________
Supervisor Contacted: ___________________________
Supervisor Title/Name: ___________________________

Did accident/incident occur on employer's premises? Yes    No
Location of accident/incident: Type ________________________________
of injury: ____________________________________________
Part(s) of body injured: ________________________________

Has employee previously injured affected body part? (If yes, attach details.): Yes    No
Has I. C. Form 19 been completed?
Severity of injury: First Aid Only    Medical Treatment    Fatality
Date of First Treatment:
Physician/Hospital authorized by Supervisor? Yes    No
Hospital/Doctor Name: ___________________________
Hospital/Doctor Address: ___________________________

Employee's post-accident/incident work status:
Injury Leave    Limited Duty    At Work    Other


CCCC SUPERVISOR'S ACCIDENT/INCIDENT INVESTIGATION REPORT

What was the employee doing prior to the injury? Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. Examples: Walking across campus; lifting tire from the car's trunk.

What happened? Explain how the injury occurred. Examples: Employee slipped on wet grass and fell to the ground; worker felt pain in lower back.

What was the injury or illness? List the part of the body that was affected and how it was affected; be more specific than "hurt" or "sore." Examples: "broken ankle", "strained back."

Did the task require PPE? Was it being used? If not, why not? Explain. Example: "Employee refused to wear eye glass protection."

Investigative Summary (In Detail, including explanation of conflicting information, if any.):

Corrective action taken or recommended to prevent future accidents:

Property Damage: N/A Vehicle Equipment Private Property
Please Describe: OSHA RECORDABLE: Yes No Case Number from Log:

If the employee died, what was the date of death?

Report Prepared by:

Title: Date of Report:
### ACCIDENT OR INCIDENT BREAKDOWN BY CHARACTERISTIC

<table>
<thead>
<tr>
<th>Nature of Injury</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Physical Injury</td>
<td>Neck (multiple injuries)</td>
</tr>
<tr>
<td>Amputation</td>
<td>Vertebral column</td>
</tr>
<tr>
<td>Angina Pectoris (Heart Disease)</td>
<td>Disc (neck, spinal column)</td>
</tr>
<tr>
<td>Burn (heat, chemical)</td>
<td>Spinal Cord</td>
</tr>
<tr>
<td>Concussion</td>
<td>Larynx (vocal cords)</td>
</tr>
<tr>
<td>Contusion (bruise, hematoma)</td>
<td>Soft Tissue (neck)</td>
</tr>
<tr>
<td>Crushing</td>
<td>Trachea</td>
</tr>
<tr>
<td>Dislocation (nerve, disc, tear)</td>
<td>Upper Extremity</td>
</tr>
<tr>
<td>Electric Shock (electrocuted)</td>
<td>Upper Arm (humerus)</td>
</tr>
<tr>
<td>Enucleation</td>
<td>Elbow (radial head)</td>
</tr>
<tr>
<td>Foreign Body (lint in eye)</td>
<td>Lower Arm (forearm)</td>
</tr>
<tr>
<td>Fracture</td>
<td>Wrist</td>
</tr>
<tr>
<td>Freezing (frost bite)</td>
<td>Hand (excluding wrist, fingers)</td>
</tr>
<tr>
<td>Loss of Hearing</td>
<td>Shoulder(s) (armpit, rotator cuff)</td>
</tr>
<tr>
<td>Heat Prostration</td>
<td>Wrist(s) &amp; Hand(s)</td>
</tr>
<tr>
<td>Hernia (from lifting)</td>
<td>Trunk (combination parts)</td>
</tr>
<tr>
<td>Infection</td>
<td>Upper Back (thoracic area)</td>
</tr>
<tr>
<td>Inflammation</td>
<td>Low Back (lumbar area)</td>
</tr>
<tr>
<td>Laceration</td>
<td>Disc (back)</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>Chest (ribs, sternum etc.)</td>
</tr>
<tr>
<td>Poisoning (not cumulative)</td>
<td>Sacrum &amp; Coccyx</td>
</tr>
<tr>
<td>Puncture (needle stick)</td>
<td>Pelvis</td>
</tr>
<tr>
<td>Rupture</td>
<td>Spinal Cord</td>
</tr>
<tr>
<td>Severance</td>
<td>Internal Organs</td>
</tr>
<tr>
<td>Sprain</td>
<td>Heart</td>
</tr>
<tr>
<td>Strain</td>
<td>Lower Extremities</td>
</tr>
<tr>
<td>Syncope (fainting, etc.)</td>
<td>Hip</td>
</tr>
<tr>
<td>Asphyxiation</td>
<td>Thigh, Upper Leg</td>
</tr>
<tr>
<td>Vascular (includes strokes)</td>
<td>Knee</td>
</tr>
<tr>
<td>Vision Loss</td>
<td>Lower Leg</td>
</tr>
<tr>
<td>All Other Specific Injuries</td>
<td>Ankle</td>
</tr>
<tr>
<td>Dust Disease</td>
<td>Foot</td>
</tr>
<tr>
<td>Asbestososis (lung disease)</td>
<td>Toe</td>
</tr>
<tr>
<td>Black Lung (coal)</td>
<td>Great Toe</td>
</tr>
<tr>
<td>Bysiniosis (silica dust)</td>
<td>Lung</td>
</tr>
<tr>
<td>Respiratory Disorders</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Poisoning - chemical</td>
<td>Abdominoplasty</td>
</tr>
<tr>
<td>Poisoning - metal</td>
<td>Buttocks</td>
</tr>
<tr>
<td>Dermatitis (any skin irritation)</td>
<td>Lumbar &amp; or Sacral Vertebrae</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>Artificial Appliance</td>
</tr>
<tr>
<td>Radiation (tissue, bones, etc.)</td>
<td>Insufficient Info to Identify</td>
</tr>
<tr>
<td>Other Occupational Diseases</td>
<td>No Physical Injury</td>
</tr>
<tr>
<td>Loss of Hearing</td>
<td>Multiple Body Parts</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Body Systems</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
</tr>
<tr>
<td>VDT Related Disease</td>
<td></td>
</tr>
<tr>
<td>Mental Stress</td>
<td></td>
</tr>
<tr>
<td>Carpal Tunnel Syndrome</td>
<td></td>
</tr>
<tr>
<td>Other Cumulative Injuries</td>
<td></td>
</tr>
<tr>
<td>Multiple Physical Injuries Only</td>
<td></td>
</tr>
<tr>
<td>Multiple Injuries, Physical &amp; Psych.</td>
<td></td>
</tr>
</tbody>
</table>

### PARTS OF BODY AFFECTED

- Head
- Skull
- Brain
- Ear(s) (eardrum)
- Eye(s)
- Nose
- Teeth
- Mouth (lips, tongue, throat)
- Facial Soft Tissue
- Facial Bones
- Neck
- Vertebral column
- Disc (neck, spinal column)
- Spinal Cord
- Larynx (vocal cords)
- Soft Tissue (neck)
- Trachea
- Upper Extremity
- Upper Arm (humerus)
- Elbow (radial head)
- Lower Arm (forearm)
- Wrist
- Hand (excluding wrist, fingers)
- Shoulder(s) (armpit, rotator cuff)
- Wrist(s) & Hand(s)
- Trunk (combination parts)
- Upper Back (thoracic area)
- Low Back (lumbar area)
- Disc (back)
- Chest (ribs, sternum etc.)
- Sacrum & Coccyx
- Pelvis
- Spinal Cord
- Internal Organs
- Heart
- Lower Extremities
- Hip
- Thigh, Upper Leg
- Knee
- Lower Leg
- Ankle
- Foot
- Toe
- Great Toe
- Lung
- Abdomen
- Abdominoplasty
- Buttocks
- Lumbar & or Sacral Vertebrae
- Artificial Appliance
- Insufficient Info to Identify
- No Physical Injury
- Multiple Body Parts
- Body Systems

### TYPES OF ACCIDENTS

#### A. Burn or Scald-Heat or Cold Exposure:
- Chemicals
- Touched Hot Pan
- Temperature Extremes
- Fire or Flame
- Boiling Water Splashed
- Dust, Gases, Fumes etc.
- Caught in, Under, or Between
- Welding Flash - Injury to Eyes
- Radiation
- Contact with, NOC
- Cold Objects/Substances
- Abnormal Air Pressure
- Electric Current

#### B. Caught In, Under or Between:
- Machine or Machinery
- Caught In, Under or Between
- Collapsing Materials (earth slides)

### Distribution:
Director, WC Administrator, Safety & Health Director
Hazardous Condition

☑ Inadequate Ventilation
☑ Insufficient Workspace
☑ Environmental Hazard
☑ Use of Inherently Hazardous Material
☑ Use Inherently Hazardous Method or Procedure
☑ Use of Inadequate or Improper Tools or Equipment
☑ Inadequate Help for Heavy Lifting
☑ Improper Assignment or Personnel
☑ Hazardous Methods or Procedures
☑ Improperly Placed
☑ Inadequately Secured
☑ Unguarded, Mechanical
☑ Inadequate Shoring
☑ Ungrounded
☑ Uninsulated
☑ Uncovered Connection Switches, etc.
☑ Unshielded Radiation
☑ Inadequately Guarded, NEC
☑ Public Hazards (off State Premises)
☑ Traffic Hazards
☑ Hazardous Condition, NEC
☑ Undetermined-Insufficient Information
☑ No Hazardous Condition

Unsafe Act

☑ Cleaning, Oiling, Adjust Moving Equipment
☑ Welding/Repairing of Equipment Without Supervisor
☑ Working on Electrically Charged Equipment
☑ Failure to Secure or Warn
☑ Failure to Shut off Equipment Not in Use
☑ Failure to Place Warning Signs & Signals
☑ Releasing or Moving Loads, etc., Without Giving Adequate Warning
☑ Horseplay, Fighting, etc.
☑ Use of Equipment or Material for Other Than its Intended Purpose
☑ Overloading
☑ Gripping Object Insecurely
☑ Taking Wrong Hold of Object
☑ Using Hand Instead of Tools
☑ Inattention to Footing or Surroundings
☑ Disconnecting or Remaining Safety Devices
☑ Replacing Safety Devices With Those of Improper Capacity
☑ Jumping From Elevations, Vehicles, etc.
☑ Running
☑ Throwing Material or Tools
☑ Riding in Unsafe Position
☑ Unnecessary Exposure Under Suspended Loads
☑ Unnecessary Exposure to Moving Materials or Equipment
☑ Driving Too Fast or Too Slowly
☑ Entering/Leaving Vehicle on Traffic Side
☑ Failure to Signal When Stopping, Turning or Backing
☑ Failure to Yield ROW
☑ Backing Without Looking for Clearance
☑ Failure to Obey Traffic Control Signs or Signals
☑ Following Too Close
☑ Other (Explain)

Supervisory Activities

☑ Inadequate Training of Employee
☑ Faulty Instruction to Employee

Employee Attributes

☑ Lack of Knowledge or Experience
☑ Improperly Trained
☑ Bodily Defects
☑ Lack of Respect for Hazard
☑ Other Insufficient Data
☑ DWI

Safety Equipment in Use

☑ Hard Hat
☑ Safety Glasses
☑ Respirator
☑ Movable Exhaust Hood
☑ Ear Protection
☑ Safety Shoes
☑ Lanyards & Lifelines
☑ Fluorescent Vest
☑ Gloves
☑ Faceshields
☑ Warning & Control
☑ Seat Belts
☑ Shoulder Harness
☑ Other Restraining Devices
☑ Safety Equipment

Distribution: Director, WC Administrator, Safety & Health Director
Supervisors should provide all injured employees with this form to complete the information concerning the accident/incident and use of leave options for any time lost from work which may result from injury. Form should be completed in detail to give an accurate account of the case. Once form is completed by the employee, supervisor completes bottom portion and submits to agency WC Administrator.

**EMPLOYEE STATEMENT**

Employee Name: ____________________________________________

Department: ________________________________________________

Division/Unit: _______________________________________________

Location: ___________________________________________ County: ______________________

Date of Injury: ___________________________ Date Injury Reported: ______________________

Name of Person Notified of Injury: _________________________________

Part(s) of Body Injured: _______________________________________

Description of Accident:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Cause of Accident:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

I understand the information above will be used by my employer to help determine liability for the injury. I acknowledge that the above statement is a true and accurate representation of this information.

Employee’s Signature ____________________________ Date ________________
USE OF LEAVE OPTIONS

This is to certify that the use of leave options available in conjunction with the lost time from work as a result of an on-the-job injury which occurred on ______________ have been fully explained to me. I understand these options are available to me only if the agency determines the claim to be compensable and accepts liability. I understand that once I elect an option, that election shall be irrevocable as to each individual incident. After careful consideration, I elect the option(s) marked below.

Place an X in the space provided to select the option(s) you desire.

☐ Option 1: Elect to take sick or vacation leave during the required seven-day waiting period and then go on worker’s compensation leave and begin drawing workers’ compensation weekly benefits.

☐ Option 2: Elect to go on workers’ leave immediately with no pay for the seven-day waiting period and then began drawing workers’ compensation weekly benefits.

Note: In either option above if the injury results in disability of more than 21 days, the workers’ compensation weekly benefit shall be allowed from the date of the disability.

☐ Option 3: Elect to supplement the workers’ compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Personnel. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation.

Note: All elections involving the use of earned sick or vacation leave are subject to their availability at the time of the incident.

__________________  ____________________
Employee Signature  Division/Unit

__________________
Employee SS#

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Supervisor Completes This Section

The above named employee was injured on ______________ and was placed on workers’ compensation leave on ______________. A Supervisor’s Accident Report or Accident Investigation Report has been completed and is attached to the IC Form 19.

__________________  ____________________
Supervisor’s Signature  Date