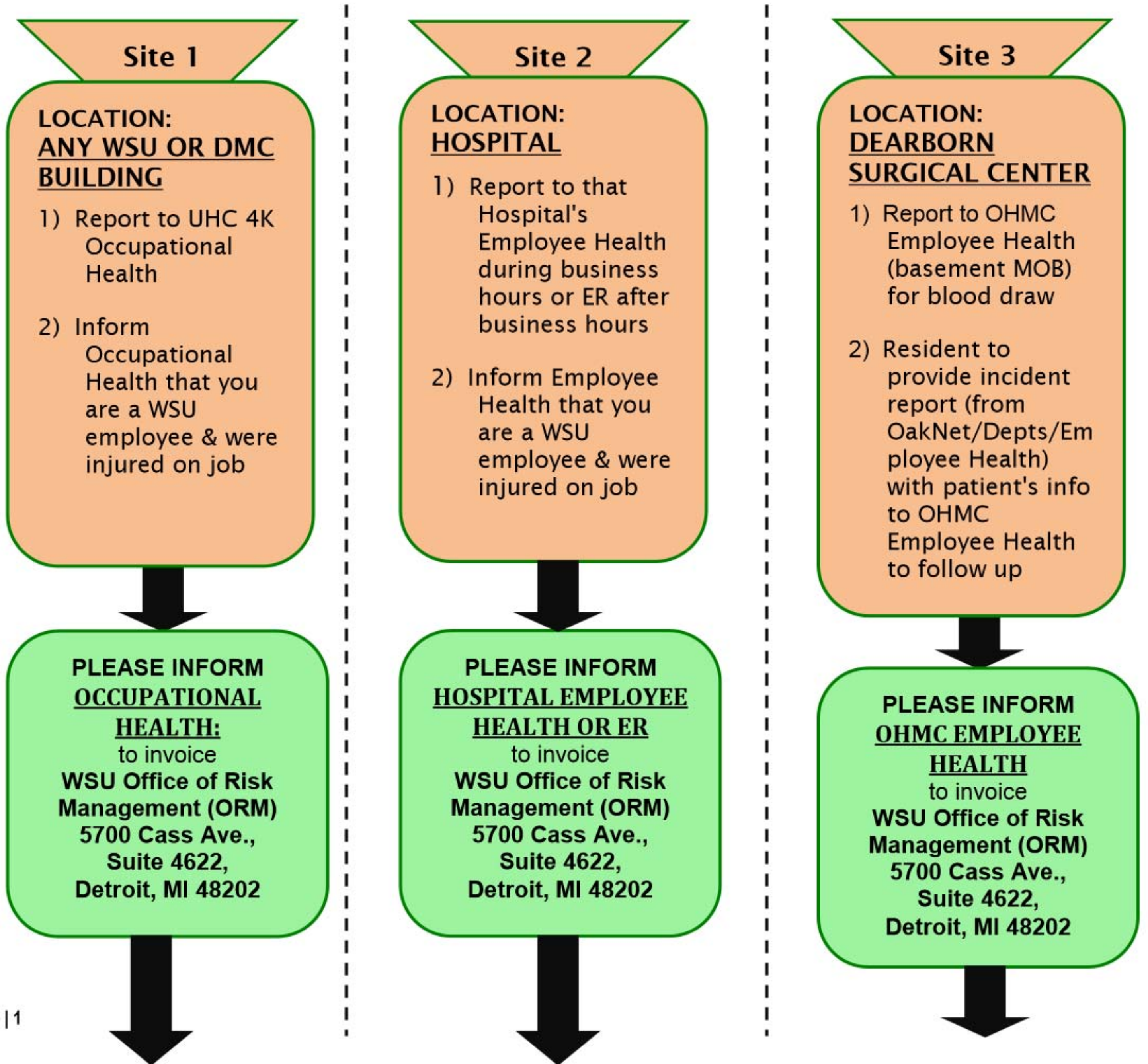
Accidental Exposure/Incident Instructions for Resident - Flow Chart

Identify the site at which the accidental exposure/incident occu

and then follow the remainder of the instructions for that site



REPORT OF INJURY FORM:

1. Download "Report of Injury" form from www.risk.wayne.edu or see last page
2. Have Program Director sign "Report of Injury" form as "supervisor"
3. Return completed form to GME office within 24 hours of injury
4. GME will submit completed "Report of Injury" form to ORM
5. Delay in submitting form may generate delinquent payment

REPORT TO OCCUPATIONAL HEALTH (UHC 4K):
the next business day for medical assessment & current work status
(Inform Occupational Health you are a WSU employee)
IF YOU MEET THE FOLLOWING CRITERIA:

- If employee received **lab work**:
  - Take results to UHC 4K for results review & a report generated so ORM is aware of employee medical issue
- If employee received **treatment along with lab work**:
  - Take results to UHC 4K and a medical report should be generated to ORM for review
- If medical report indicates need for **3-6 month treatment**:
  - Employee should report to UHC 4K for follow up
- If medical report indicates **no further treatment** is necessary:
  - Employee does not need to follow up at UHC 4K

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Report of Injury

Type or Print Neatly.

Name (Last, First, Middle) | Social Security No.

Address (Street, City, State, Zip) | Telephone No.

Date of Injury: | Time of Injury: | A.M. P.M.

Location (Building, Address or Area)

Accident Reported to: | Name | Title

Witnesses: | Full Name | Address (Street, City, State, Zip) | Telephone No.

1.

2.

Treating Physician: Full Name | Address

Hospital (if hospitalized): Full Name | Address

Description of alleged injury: Complete information requested for each category. Be specific.

Describe the injury or illness (i.e., amputation, burn, cut, fracture, sprain, etc.).

Part of body directly affected by the injury or illness (i.e., head, arm, leg, circulatory system, etc):

Describe the events that caused the injury (i.e., fall, operating machinery, exposure to chemicals, etc.):

Name the object or substance which directly injured the person (i.e., knife, acid, floor, etc):

Employees MUST complete the following information:

Birthdate (mm/dd/yy) | If under 18, working permit date (mm/dd/yy) | Sex: Female Male | No. of Dependents (under age 16):

Tax Filing Status: | Single | Married, Filing Jointly | If married, spouse is supported at least 50% by injured.
| Single, Head of Household | Married, Filing Separately |

Other family members supported at least 50% by injured (specify):

Lost Day(s) Due to Injury: Yes No | Date of Last Day Worked: | Date returned to work/ estimated length of disability:

If approved for Workers' Compensation, I would like my benefits supplemented 20%, utilizing any available Illness or Vacation time that I have. Yes No

Classification | **Department** | **Date of Hire**

Supervisor's Name | Hours Worked per week:

Campus Address | Telephone No.

Second Employer (if applicable): Name

Address (Street, City, State, Zip)

Employee's Signature/Date:

Supervisor's Signature/Date: