University of Massachusetts Amherst

Office of Human Resources
181 President's Drive
325 Whitmore Admin. Building
Amherst, MA 01003-9313

Workers' Compensation
Telephone: 413.545.6114
Facsimile: 413.545.0483

This form is intended for internal use for all Human Resources Division/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed via eServices within 48 hours of an Industrial Accident. Please print clearly.

EMPLOYEE

Soc. Sec. #: ____________________ Date of Injury: ____________________ (mm/dd/yyyy)

Department: ____

Name: ____
(First) (Middle) (Last)

Sex: Male Female Employee ID#: ____________ Record #: ______

Address: ____

City: ____________________ State: _____ Zip: ______________

Home Telephone: ____________ Date of Birth: ____________ Marital Status: S M

EMPLOYER

State Hire Date: ________________ Department Hire Date: ________________

Status: Full-Time Employee Part-Time Employee Work Hours/Wk: ________

Shift 1st 2nd 3rd Number of scheduled days off per week: ____________

Occupation: (Official Position Title) ________________________________

Functional Title: ____

Payroll Funding Source: State Payroll Trust Funded Federal Funded

INJURY INFO

Injury Time: ____________ am / pm Date Reported: ________________________

Time work began on day of event: __________ am / pm

Event occurred: Before During After Work Shift 3rd Party Claim: Yes No

Describe how injury/illness occurred:

What was employee doing (eg, pouring cleaning solution into a bucket):

____

How did the injury/illness occur (eg, cleaning solution splashed):

____

What was the source of the injury/illness (eg, cleaning solution):

____

INJURY INFORMATION

Nature of Injury/Illness (eg, chemical burn to right eye):

____

Body part(s) affected (include right, left or both):

____

Injury Detail: Use drop down menu below for selection, otherwise see page 5.

Select Body Part(s): Select Injury:

Select One or More Injury Categories:

Fall	Lifting	MVA (Motor Vehicle Accident)
Assault	Exposure to Harmful Substances	Repetitive Use
Equipment	Moving/Walking	Stress/Heart Attack
Burn	Cut	Restraint
Needlestick/Bloodborne Pathogen Exposure		Other ______________________

Severity of Injury or Illness:

(1) Minor injury; no likely lost time; no likely medical bills

(2) Small injury; no likely lost time; possible medical bills

(3) Moderate injury; possible lost time; probable medical bills

(4) Significant injury; probably 0 – 5 days of lost time and medical bills

(5) Severe injury; probably 5 plus days lost time and medical bills

Where the Injury Occurred:

Building: ____

Injury Location: ____

Example: stairwell, south walkway, office

INVESTIGATION

Was the incident the result of a violent act? Yes No

Was the claimant engaging in usual job activities? Yes No

If no, explain: ____

____

Injury reported to: ____

(Name, Title)

Did the Injured / Ill worker:

a. Lose consciousness? Yes No

b. Require medical treatment more than first aid? Yes No

c. Have an injury from a contaminated needlestick or other sharp device? Yes No

d. Have a significant work-related injury/illness diagnosed by a health care professional? Yes No

e. Require transfer to another job or modified duty? Yes No

I N T E R N A L I N V E S T I G A T I O N

If employee died as a result of injury/illness, what was the date of death? _____/_____/_____

Supervisor: Are you satisfied that the injury occurred as stated? Yes No

If no, explain: ____

____

Manager: Are you satisfied that the injury occurred as stated? Yes No

If no, explain: ____

____

Was the incident witnessed? Yes No

If yes, provide the names of witnesses and ask that each prepare a witness statement.

Witness: Name______________________________Title___________________Phone____________

Name______________________________Title___________________Phone____________

Did employee seek medical attention? Yes No

If yes, where?

a. Facility: ____

b. Address: ____

(street, town, zip code)

Did the employee seek medical attention away from the worksite?	Yes	No	
Was the employee treated in an emergency room?	Yes	No	
Was the employee hospitalized overnight as an in-patient?	Yes	No	
Do you feel the employee would benefit from any referral to Rehabilitation?	Yes	No	Unknown
Do you feel claim warrants further investigation?	Yes	No	

Please attach if possible any information you feel would be useful to HRD/WC Section (i.e. claimant's job description, etc.) in managing this claim.

______________________________________ ______________________________________

Supervisor Signature Please print name

Title: ______________________________ Date______________________________

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WORKERS' COMPENSATION
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Employee's Name: ____

Social Security Number ________________________

Address: ____

____

____

Telephone Number: ___________________________________

Employing Agency and Location: UMA4
___UMASS Amherst____

Date of injury: ______________________
mm/dd/yyyy

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, **any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law**. I understand that HRD may share this information with my employer, medical and or vocation rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

Signature: ____________________________________ Date: _________________________

Body Parts List

Head	Hip/Buttocks/Groin (Buttocks)	**Upper Extremities**
Brain	Hip/Buttocks/Groin (Groin)	Arm(s), unspecified (Left)
Ear(s), unspecified	Hip/Buttocks/Groin (Hips)	Arm(s), unspecified (Right)
Ear(s), external	Shoulder(s) (Left)	Arm(s), unspecified (Both)
Ear(s), internal	Shoulder(s) (Right)	Arm(s), unspecified (Armpit)
Eye(s) (Left)	Shoulder(s) (Both)	Arm(s), upper (Left)
Eye(s) (Right)	Trunk, Multiple	Arm(s), upper (Right)
Eye(s) (Both)	**Lower Extremities**	Arm(s), upper (Both)
Face, unspecified	Leg(s), unspecified (Left)	Elbow(s) (Left)
Jaw, Chin	Leg(s), unspecified (Right)	Elbow(s) (Right)
Mouth & Throat (Lips)	Leg(s), unspecified (Both)	Elbow(s) (Both)
Mouth & Throat (Multiple)	Knee(s) (Left)	Arm(s), lower (forearm) (Left)
Mouth & Throat (Tongue)	Knee(s) (Right)	Arm(s), lower (forearm) (Right)
Mouth & Throat (Tooth/teeth)	Knee(s) (Both)	Arm(s), lower (forearm) (Both)
Mouth & Throat (Unspecified)	Leg(s), lower (e.g. calf, shin) (Left)	Arm(s), multiple (Left)
Mouth & Throat (Internal (e.g. vocal cords, larynx))	Leg(s), lower (e.g. calf, shin) (Right)	Arm(s), multiple (Right)
Nose	Leg(s), lower (e.g. calf, shin) (Both)	Arm(s), multiple (Both)
Face, multiple	Leg(s), multiple (Left)	Wrist(s) (Left)
Face (Cheeks)	Leg(s), multiple (Right)	Wrist(s) (Right)
Face (Forehead)	Leg(s), multiple (Both)	Wrist(s) (Both)
Scalp	Leg(s), upper (e.g. thigh, hamstring) (Left)	Hand(s), not wrist/fingers (Left)
Skull	Leg(s), upper (e.g. thigh, hamstring) (Right)	Hand(s), not wrist/fingers (Right)
Head, Multiple	Leg(s), upper (e.g. thigh, hamstring) (Both)	Hand(s), not wrist/fingers (Both)
Head	Ankle (Left)	Finger(s)
Neck	Ankle (Right)	Upper Extremities, multiple (Left)
Neck & cervical vertebrae	Ankle (Both)	Upper Extremities, multiple (Right)
Trunk	Foot or Feet, except ankle/toe (Left)	Upper Extremities, multiple (Both)
Trunk, UNS	Foot or Feet, except ankle/toe (Right)	**Other**
Abdomen, internal organs/hernia	Foot or Feet, except ankle/toe (Both)	Other (Body system)
Back	Toe(s)	Other (Multiple body parts)
Chest/Breastbone (Internal organs)	Lower Extremities, multiple (Left)	Non-Classifiable
Chest/Breastbone (Ribs, breastbone)	Lower Extremities, multiple (Right)	
	Lower Extremities, multiple (Both)	

List of Injury Types

Acute Injuries	**Mental disorders**
Amputation, enucleation	Mental disorders (Anxiety attacks)
Asphyxia, suffocation	Mental disorders (Other mental disorder or syndrome)
Burn, heat	Mental disorders (Stress)
Burn, chemical	**Other Work-related diseases/disorders**
Concussion	Other occupational disease
Contusion, crushing, bruise	Diseases of central nervous system
Cut, laceration, puncture (Except needlestick injury)	Diseases of peripheral nerves and ganglia
Cut, laceration, puncture (Needlestick/sharp injury)	Disease of the blood and blood forming organs
Cut, laceration, puncture (Splinter, chip (foreign body))	Disease of the gastro-intestinal tract
Dislocation	Carpal tunnel syndrome
Fracture	**Poisoning and toxic effects**
Effects of exposure to low temperature	Other poisoning due to toxic materials
Effects of environmental heat	Effects of lead
Hernia, rupture	**Respiratory conditions**
Effects of radiation	Other respatory condition
Scratches, abrasion	Upper respiratory condition (e.g. allergic rhinitis)
Sprains, strains	Asthma
Multiple injuries	Asbestosis
Effects of atmospheric pressure	Silicosis
Bite/Burn/Other Injury (Bite, animal)	Influenza/Pneumonia (Influenza)
Bite/Burn/Other Injury (Bite, human)	Influenza/Pneumonia (Pneumonia)
Bite/Burn/Other Injury (Bite, insect)	**Skin conditions**
Bite/Burn/Other Injury (Burn, other)	Dermatitis
Bite/Burn/Other Injury (Other injury)	Infections of the skin
Electric shock/electrocution	Other skin conditions
Heart/Circulatory System Conditions	**Tumor, cancer**
Heart/Circulatory System (Heart condition/attack)	Tumor, unspecified
Heart/Circulatory System (High blood pressure)	Malignant Tumor
Heart/Circulatory System (Stroke or other circulatory condition)	Benign Tumor
Hearing and eye disorders	**Symptoms, ill defined conditions**
Hearing loss or impairment	Symptoms, ill defined conditions (Back pain, hurt back)
Conjunctivitis	Symptoms, ill defined conditions (Chest pains)
Other diseases of the eye	Symptoms, ill defined conditions (Dizziness)
Infectious or parasitic diseases	Symptoms, ill defined conditions (Headaches, migraine)
Tetanus	Symptoms, ill defined conditions (Nausea, vomiting)
Tuberculosis	Symptoms, ill defined conditions (Pain/Soreness, except back or chest)
Infectious/Parasasitic Diseases (Lyme disease)	Symptoms, ill defined conditions (Sick building syndrome)
Infectious/Parasasitic Diseases (Other infectious or parasitic diseases)	Symptoms, ill defined conditions (Other symptoms and ill defined conditions)
Hepatitis - viral	**Other**
Inflammation of the joints or tendons	No injury or illness
Joint Inflammation, etc. (Arthritis)	Damage to prosthetic devices
Joint Inflammation, etc. (Bursitis)	Non-classifiable (Exposure to saliva/body fluids)
Joint Inflammation, etc. (Other Inflammation of the joints)	Non-classifiable (Non-classifiable)
Joint Inflammation, etc. (Sciatica)	Complications peculiar to medical care
Joint Inflammation, etc. (Tendonitis)	