CAMBRIDGE

SELF

EMPLOYEE'S REPORT OF INJURY

Information About You

Your Name: _____

Address: _____

Phone #: _____

Employer's Name: _____

Marital Status: S ☐ M ☐ D ☐ W ☐ Sex: M ☐ F ☐

Children under 18 (sex and age: _____

Height: _____ Weight: _____ Average Weekly Wage: _____

Length of Employment: _____ Days & Hours Worked: _____

Other Employment: _____

Information About Accident

Date of Accident: _____ Time: _____

Place of Accident: _____

_____

What were you doing before the accident? _____

_____

What happened? _____

_____

_____

Witnesses, if any: _____

_____

Who did you report the injury to? _____

_____

What date did you report it? _____

_____

Information About the Injury

What part of your body was injured? _____

Any other part or parts injured? _____

What kind of injury (strain, cut, broken bone)? _____

_____

Exact location of pain(s): _____

_____

Information About Treatment

What doctor is treating you (name, address, phone #)? _____

_____

Who is your family doctor? _____

What clinic is treating you? _____

What hospital is treating you? _____

What treatment are you getting (medication, physical therapy, rest, etc.)? _____

_____

Has the doctor told you to be off work? _____

_____

General Information

Have you ever injured the same part of your body before? _____

Explain: _____

Have you ever injured any other part of your body before? _____

Explain: _____

Do you have any serious illness (Diabetes, High Blood Pressure, etc.)? _____

Explain: _____

Have you understood the questions you have answered? _____

Signed: _____

Date: _____

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SUPERVISOR'S INVESTIGATION REPORT

The unsafe acts of persons and the unsafe conditions that cause accidents can be corrected only when they are known specifically. It is your responsibility to find them and name them and to state the remedy for them in this report.

	Code
Company	Branch or subsidiary

Location of accident: *(The name or number of building, store, dept., floor, etc.)*	Date and hour of accident

Name of injured person	Injured's dept. or division	Injured's job or position

Describe the injury

Describe the accident *(State what the injured was doing and the circumstances leading to the accident.)*

Unsafe condition *(Describe as oily floor, poor light, lack of guards on belts and gears, broken steps, etc.)*

Unsafe act--Unsafe work procedure *(Described as removed guard, adjusted moving machine, or a specific item of substandard procedure, lack of planned safely, etc.)*

Remedy *(As a supervisor, what action have you taken or do you propose taking to prevent a repeat accident.)*

Supervisor	Reviewed and approved by	Date report prepared

(Use reverse side for sketch and additional detail)

ACCIDENT INVESTIGATION

Each accident regardless of whether it results in a personal injury, property damage, or a near miss should be investigated to determine the actual cause and to take proper action to prevent recurrence.

The accident should be investigated by the supervisor of the injured employee or department involved. The investigation should be conducted as soon as possible to get the most accurate information. Your purpose is to obtain facts and prevent recurrence - not place blame.

STEPS TO FOLLOW

1. Obtain notice of event.
2. Go to the scene immediately.
3. Find out what happened.
4. Determine accident CAUSES.
5. Develop and implement corrective action.
6. Complete all sections of the form.
7. Report to management.
8. Follow up.

This Guide is to stimulate questioning in determining the DIRECT and INDIRECT accident causes.

QUESTIONS TO ASK	IF THE CAUSES APPEAR TO BE	
	CONDITIONS	ACTIONS
WHY	!! did it exist? !! had no one noticed and corrected it?	!! was it being done? !! was it being done this way? !! was it (job or detail) necessary?
WHAT	!! caused it to exist? !! caused it to be involved?	!! was its purpose? !! other way could it be done? !! details could be eliminated? !! instructions were not followed?
WHERE	!! was it? !! was its source? !! else does it exist? !! can I find out?	!! should it be done? !! else is it being done?
WHEN	!! did it occur? !! do similar conditions occur?	!! should it be done?
WHO	!! was responsible for it? !! can give me answers? !! should take corrective action?	!! is best qualified to do it? !! can give me answers? !! can show me what was being done?
HOW	!! should it be corrected? !! can it be avoided in the future?	!! is the best way to do it? !! can it (job or detail) be improved?

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WITNESS STATEMENT

Claim No. _____

Date of accident _____ About what time? _____

Where did it happen? _____

Did you see it? _____ If not, how soon after did you arrive? _____

Where were you when accident occurred? _____

Was weather a factor? _____ If yes, describe conditions _____

Condition of accident area _____

What precautions had been taken? _____

Did any defects contribute to the accident? _____

If yes, name and describe _____

Did the injured party's (ies) actions contribute to the accident? _____

If yes, how _____

Name of injured _____

Give name and address of other witnesses _____

Describe how accident occurred? _____

Did you hear anyone admit fault? _____ Who? _____

In your opinion, who was to blame? _____

Why? _____

Are you a personal friend or relative of the injured party? _____

If yes, state relationship _____

Date: _____

Name: _____ Signature: _____

Home Address: _____ Phone: _____

Business Address: _____ Phone: _____

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HIPAA Privacy Authorization
For Disclosure of Protected Health Information
Relevant to Pending Claims

Patient's Name:_____

Address: _____ Date of Birth: _____

1. I make this Authorization for the purpose of copying records in connection with a claim to which I am a party.
2. This Authorization is directed to and applies to protected health information maintained by:

(Hospital, Physician, Medical Provider, etc.)_____

_____

_____

_____

_____

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing departments to release any and all medical records and information from my date of birth to the present unless specified otherwise, relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2, psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.
4. This information is to be released for copying purposes to:_____ _____ or their agent,_____.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.
6. This authorization shall be in force and in effect until the conclusion of the pending claim unless otherwise specified.
7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.
8. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.
9. A copy of this authorization is as valid as the original.

All Pertinent Sections Of This Form Must Be Completed Before Signing

_____ X_____

Date Signature of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority or Relationship

Print Name of Patient or Personal Representative