Carnegie Mellon University
Human Resources

Injury/Illness Report

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

This Injury/Illness Report must be completed when a work-related injury or illness has occurred. This report provides important information required by the university's workers compensation insurance provider and helps the university and OSHA develop a picture of the extent and severity of work-related incidents.

The completed Injury/Illness Report must be either faxed to CMU Human Resources at 412-268-7068 or emailed to Matt McCabe, Leaves Manager, at mmccabe@andrew.cmu.edu as soon as possible (within 24 hours) following a work-related incident.

Completed by:
Title:
Phone:
Fax:
Date:

If you need additional copies of this form, you may photocopy and use as many as you need.

❶ Employee / Working Student Information

Please print or type clearly

Last Name, First Name, M.I. ❒ Male ❒ Female		Status: ❒ Employee ❒ Working student
Job Title	Department	Work Phone
Date of Birth	Normal Starting Time ____________ Normal Quitting Time ____________	Date of Hire (*leave blank if unknown*)
Home Address: Street	City	County of Residence
State	Zip Code	Home Phone
Supervisor's Name	Supervisor's Phone	Date supervisor was first made aware of injury/ illness

❷ Description of Incident

Date of injury/illness:	Time employee began work: ______________________	
Time of event: _______________________	❒ Check if time cannot be determined.	Was Security notified? ❒ Yes ❒ No

Where did injury/illness occur? (List specific location, i.e. Wean Hall in front of elevator; Baker Hall stairwell, 2nd landing):

What had the employee been doing just before the injury/illness resulted? (Be specific about equipment and activities, e.g., walking down steps, heating sulfur with open flame for chemistry experiment; slicing lunch meat with electric slicer)

What happened? How did the injury occur? (e.g., ladder slipped on wet floor and employee fell 20 feet; hand slipped and finger went into meat slicer, beaker broke and plume of smoke went into face)

What object or substance directly harmed the employee? (e.g., concrete floor, meat slicer blade, chlorine)

Did individual receive supervised training for the type of work being performed? ❒ Yes ❒ No	If yes, by whom and when?

How can this type of injury/illness be avoided in the future? (Be specific, e.g., update procedure, provide additional training, submit a work order to address issue)

If there was a witness(es) to the incident, please list name(s) and telephone number(s).

❸ Description of Treatment

Was injured employee treated? ❒ Yes ❒ No	Date treatment was received:	
Name of treating physician or other health care professional:	Was employee treated in an emergency room? ❒ Yes ❒ No	Was employee hospitalized overnight as an in-patient? ❒ Yes ❒ No

Where was treatment given (at worksite or health care facility name and address) – *leave blank if unknown*.

Nature of injury (sprain, bruise, inhalation of chemicals, etc.)	Specific part of body injured (i.e. left index finger, right knee)

Is/was employee away from work as a result? ❒ Yes ❒ No	Last date worked: ______ Last day paid in full: ______ Date returned to work: ______ Number of days missed (Write '0' for none): ______

If the employee died, when did death occur? Date: ______

❹ Signatures

______ Injured's Signature ______ Date

______ Supervisor's/Department Representative's Signature ______ Date

Submit a copy of this form to the Office of Human Resources via either fax at 412-268-7068 or email at mmccabe@andrew.cmu.edu immediately (within 24 hours) following the incident. Retain a copy for your records. DO NOT SUBMIT VIA CAMPUS OR U.S. MAIL.

Questions about reporting a work-related injury or illness? Contact Human Resources at 412-268-4600. Revised 09/19

ACKNOWLEDGMENT OF EMPLOYEE RIGHTS AND DUTIES UNDER SECTION 306 OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

1. All employees who are injured on the job and require medical treatment must treat with one of the health care providers listed on their employers' panel for a period of ninety (90) days. Should the employee not comply with the foregoing, the employer will be relieved from liability for payment for the services rendered during such applicable period.

2. Employees faced with an immediate medical emergency may treat with the medical care provider of their choice. However, subsequent treatment must be obtained from one of the employer's designated health care providers for the first ninety (90) days from the date of first treatment by that designated provider.

3. Following expiration of the ninety (90) day treatment period, an employee may treat with a non-designated health care provider so long as the employee provides notice of the change to his/her employer within five (5) days of the first visit to that provider. Failure to provide such notice may relieve the employer of the obligation to pay for services rendered by the non-designated provider. All health care providers must provide employers with an initial medical report ten (10) days following the employee's first visit and on a monthly basis so long as treatment continues.

4. Both designated and non-designated physicians must accept as payment in full the amount due as calculated pursuant to the provisions of the Act. No provider may charge or accept from an injured worker any greater amount, unless the treatment was for an injury or illness not covered by the Workers' Compensation Act.

5. Employees who refuse reasonable medical treatment, including hospitalization, surgery, medication and/or supplies will forfeit all rights to compensation or any increase in disability status resulting from such refusal.

6. Under the provisions of the Act, employers are required to provide injured employees with reasonable hospital and physician services, medicine, supplies, or orthopedic appliances and prosthesis. If a prosthesis is required, the employer will provide for training for use of the prosthesis as well as replacement prosthesis. Continuing medical care if prescribed by a physician will also be covered, regardless of whether loss of earning power occurs.

7. If hospitalization is required as a result of a work-related injury, the employer will pay for semi-private room. Cost for a private room will be covered only in the event a semi-private room is not available.

8. Should invasive surgery be prescribed by an employer-designated provider, the employee shall be permitted to obtain a second opinion from a provider of the employee's own choice, at the expense of the insurer. If the second opinion differs from the opinion of the employer-designated provider, the employee may choose which course of treatment to follow provided the second opinion provides a specific and detailed course of treatment. However, if the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the employer's designated providers for a period of ninety (90) days from the date of the visit to the provider of the employee's choice.

This is a summary of some of your rights and duties under the Workers' Compensation Law of Pennsylvania. Questions concerning the above described rights and duties under Section 306 may be directed to the Pennsylvania Bureau of Workers' Compensation Help Line at 1-800-482-2383 or 717-772-4447.

EMPLOYEE:

I HAVE READ THE ABOVE AND UNDERSTAND MY RIGHTS AND RESPONSIBILITIES.

EMPLOYEE PRINT NAME: ____

SIGN NAME ____________________________________ DATE______________

SUPERVISOR/DEPARTMENT REPRESENTATIVE:

IF THE EMPLOYEE IS UNABLE OR REFUSES TO SIGN, IT IS ACKNOWLEDGED THAT THE EMPLOYEE WAS PROVIDED A COPY OF THIS DOCUMENT.

SUPERVISOR/DEPARTMENT REPRESENTATIVE PRINT NAME: __________________________

SIGN NAME ____________________________________ DATE ______________

Send a copy either via fax to Human Resources at 412-68-7068 or email to mmccabe@andrew.cmu.edu. The employee should also retain a copy.

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Carnegie Mellon University
Human Resources

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412-268-4600 | Fax: (412) 268-7068

Matt McCabe, Leaves Manager:
mmccabe@andrew.cmu.edu

WORKERS' COMPENSATION INFORMATION

In Pennsylvania, the workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania 800-482-2383
Telephone number outside of this Commonwealth 717-772-4447 TTY
800-362-4228 (for hearing and speech impaired only)
PA Workers' Compensation Services

ACKNOWLEDGMENT

I, ____,

employee of ____, hereby

certify that I was provided with the above statement on ______/______/________ (date).

____
Employee signature

NOTICE TO EMPLOYEES

CARNEGIE MELLON UNIVERSITY
HAS PROVIDED FOR THE PAYMENT OF BENEFITS UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT

Any employee injured at work should report immediately to his/her supervisor.

IN THE CASE OF WORK-RELATED INJURY:

A. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies.

B. To insure that your employer will pay for medical treatment, you must select one of the below-listed physicians for medical treatment. For a life threatening emergency, report to UPMC-Shadyside Hospital's Emergency Department or the nearest hospital.

C. To ensure that your employer or the insurance company will pay for your follow-up medical treatment, you must select one of the below-listed physicians or practitioners of the healing arts. To schedule an appointment please call the designated phone numbers.

Concentra Medical Center - 412-621-5430
120 Lytton Avenue, Suite 275, Pittsburgh, PA 15213

Emergency Medicine Physician - 412-623-2063
UPMC Shadyside Hospital, 5230 Centre Avenue, Pittsburgh, PA 15232

Tri-State Orthopaedics & Sports Medicine - 412-696-0300
300 Chapel Harbor Drive, Suite 300, Pittsburgh, PA 15238

D. If you need ongoing treatment, you must receive treatment from one of the physicians listed for ninety (90) days from the date of your first visit.

E. After this 90-day period, if you still need treatment, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify the Benefits Office (Phone: 412-268-4600) of this action within five days of your visit to the practitioner of your choice.

F. If one of the physicians listed above refers you to another licensed specialist, your employer or their insurer will pay the bill for these services if the treatment is related to the work-related condition or injury.

G. **Remember, it is important to tell your employer about your injury immediately!**