

University of Hawai'i
REPORT OF WORK-RELATED INJURY/ILLNESS

I. Employee's Statement (to be completed by Employee or WC Coordinator in consultation with Employee)

Name: _____ Dept/College: _____
Last First M.I.

Home Address: _____ Marital Status: Married () Single ()
Street/P.O.Box
City State Zip Home Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security No.: _____
mo day year

Date of Injury: _____ Time of Injury: _____ a.m. _____ p.m.
mo day year

Time Began Work on Day of Injury: _____ a.m. _____ p.m.

Date injury/illness reported to Supervisor or WC Coordinator (College Personnel Officer): _____

Name of Supervisor: _____

List names and phones numbers of any witnesses to injury/illness: _____

Any outside employment? Yes [] No [] If yes, list name and address of employer: _____

Did you lose any time off from work? Yes [] No [] If yes, indicate dates: From _____ To _____

Fully describe how, when and where the injury occurred (e.g., I was in Hawai'i Hall Room 5 moving a 60# box of copier paper from the bottom shelf to the hand truck when I felt a sharp pain.):

Identify body part and extent of injury/illness (e.g., muscle strain in lower back): _____

Identify the tools, equipment, or materials, if any, you were using at the time of the accident: _____

Identify any protective equipment you were using at the time of the accident: _____

If you received medical treatment other than first aid, provide name and address of medical provider: _____

If you were hospitalized for this injury/illness, provide name and address of hospital: _____

Have you ever had a similar injury/illness? Yes [] No [] If yes, please explain and list names and addresses of previous medical providers who have treated you: _____

I hereby certify that the statements on this form are true and correct to the best of my knowledge.

Employee's Signature

Date

II. Supervisor's Statement

Date on which the injury/illness described above was reported to you: _____

Reason for delay, if any, in informing WC Coordinator: _____

Is the Employee's description of his/her work assignment at the time of injury/illness accurate? Yes [] No []

If no, explain: _____

Was the Employee performing the assigned duties and responsibilities at the time of injury/illness?

Yes [] No [] If no, explain: _____

Additional information (provide relevant information; e.g., special circumstances relating to the injury/illness, contextual information, etc.) _____

Supervisor's Name (Print)

Supervisor's Signature

Phone No.

II. Authorized Workers' Compensation Coordinator (Designated College PO/AO)

Employee-Claimant Employment Information:

Position Title: _____ Class Code: _____ Gender: ___ Male ___ Female

Date of Hire: _____ BU: _____ Pay: \$_____hourly \$_____ monthly

Type of Appointment: ___ Regular ___ Temporary ___ Casual/Emergency ___ Part-time (Hrs worked per week: _____)

If injury/illness is fatal, date of death: _____ Date DLIR - OSH Notified: _____

Employing Agency Code: 22-_____

14-digit payroll account code and % at time of injury:	_____	_____ %
	_____	_____ %
	_____	_____ %
	_____	_____ %
	_____	_____ %

Reason for delay, if any, in submitting report to FICOH: _____

Additional Information (Provide any other relevant information; e.g., knowledge of concurrent employment if not otherwise indicated by Employee; special circumstances relating to the injury/illness) : _____

I understand that the Employer's Report of Injury/Illness must be submitted to DLIR by First Insurance Company of Hawai'i within seven (7) days of the Employee's notice to Employer in compliance with Chapter 386, HRS. The UH Form 79 (OHR) Report of Work-Related Injury/Illness and UH Form 42 (OHR), Computation of Average Weekly Wages for Temporary Disability Payments were timely submitted to First Insurance Company of Hawai'i by FAX to 527-7511 by:

Authorized WC Coordinator (print)

WC Coordinator Signature

Phone

Date

**FAX to: First Insurance Company of Hawai'i and OHR-WC
Original: WC Coordinator (do not file in employee's personnel folder)**