NORTHEASTERN UNIVERSITY

WORKERS' COMPENSATION INCIDENT/ILLNESS/NEAR MISS REPORT FORM

For reporting work-related incidents, injuries, illnesses and near misses.

Instructions

- **Part A** is to be completed by the employee or supervisor **immediately** after any on-the-job incident or near miss. All questions must be answered. The employee's signature is required.

- **Part B** is to be completed and signed by the supervisor. Discuss the occurrence in detail with the employee prior to completing this section.

- If injured, the injured employee must also sign the attached Medical Records Release Authorization.

- If equipment is involved, the specific equipment involved must be taken out of service until it is inspected by the Supervisor or Risk Services and determined to be safe and fit for use.

- If employee received medical treatment, a work clearance note is required prior to returning to work.

- Send completed form including signed medical authorization within 24 hours to risk@northeastern.edu or deliver in person to Risk Services CP 301.

    - Give one copy to the employee
    - Keep one copy for the department's records

- Form should be sent to Risk Services immediately but no later than **24 hours** post-accident. If the form is missing information or unsigned, the form can be submitted to Risk Services and missing information can be supplemented.

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The employee and supervisor must complete and file this report within 24 hours of an incident or near miss. Send completed form to risk@northeastern.edu or deliver in person to Risk Services CP 301.

Questions? Please contact the Claims & Risk Specialist at (617) 373-2690 or email us at: risk@northeastern.edu.

<table>
<tr><th colspan="4">PART A: EMPLOYEE'S STATEMENT OF INCIDENT/ILLNESS/NEAR MISS</th></tr>
<tr><td rowspan="2">Employee Name:
(LAST NAME, FIRST NAME)</td><td>Employee ID:</td><td colspan="2">Date of Birth:</td></tr>
<tr><td>SSN:</td><td colspan="2">Date of Hire:</td></tr>
<tr><td colspan="4">Home Address:
(INCLUDE CITY, STATE & ZIP CODE)</td></tr>
<tr><td>Preferred Phone:</td><td colspan="3">Preferred Email:</td></tr>
<tr><td>Date and Time of Occurrence:</td><td>Time Employee Began Work:</td><td colspan="2">Hours worked within 48hr period preceding occurrence:</td></tr>
<tr><td colspan="4">Location of Occurrence:
(INCLUDE CITY, STATE & ZIP CODE)</td></tr>
<tr><td colspan="4">Description of incident/illness/near miss. Attach a separate sheet if needed:</td></tr>
<tr><td>If injured or ill, describe specifics:</td><td colspan="3">If injured or ill, were you ever treated for a similar condition? If yes, give details. Attach a separate sheet if needed:</td></tr>
</table>

Employee's Signature: _____ Date Completed: _____

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PART B: SUPERVISOR'S STATEMENT	
Did employee receive medical treatment?	If employee was transferred to a hospital, please indicate which hospital and how the employee was transported.
Description of incident/illness/near miss. Attach a separate sheet if needed and photos, if available:	
* If equipment was involved, provide details, i.e., equipment make, model and any defects or concerns: (PROVIDE PHOTOS)	
Was there contact with bodily fluids or hazardous materials? If yes, provide details:	
Weather conditions at the time of occurrence:	How could a similar occurrence be avoided?
Name and phone numbers of witnesses, if any:	
Did employee lose time from work? If yes, first full day of disability:	
** Has employee returned to work? If yes, date returned:	

* If equipment is involved, the specific equipment involved must be taken out of service until it is inspected by the Supervisor or Risk Services and determined to be safe and fit for use.

** If employee received medical treatment, a work clearance note is required prior to returning to work.

Supervisor's Signature: _____ Date Completed: _____

Printed Name: _____ Phone Ext: _____

MEDICAL RECORDS RELEASE AUTHORIZATION

In order for your claim to be fully evaluated for purposes of determining your eligibility or the receipt of benefits, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim, the payment of benefits or the administration of the insurance program under which the claim has been made. Your acceptance of benefits shall be considered an acceptance of the terms in this medical authorization, unless you indicate to the contrary in writing. Your decision not to authorize the release of any of the information described in this document does not eliminate any right that PMA Companies or any other entity may have, under state and federal law, to obtain or disclose the information without an authorization. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to PMA Companies, P.O. Box 5231, Janesville, WI., 53547-5231, otherwise this authorization will continue to be valid.

Authorization to Release Medical Information

I hereby authorize any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts and any hospital, including the Veteran's Administration, or medical transportation company, to release to any of the PMA Companies (Pennsylvania Manufacturers' Association Insurance Company, Manufacturers Alliance Insurance Company, Pennsylvania Manufacturers Indemnity Company, PMA Management Corp. of New England, Inc. and PMA Management Corp.) and their subsidiaries, affiliates, representatives and agents (collectively, PMA Companies), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof. This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems, but shall specifically exclude "genetic information" as defined in The Genetic Information Nondiscrimination Act including your family medical history, the results your or a family member's genetic tests, the fact that you or a family member sought or received genetic services and genetic information of a fetus carried by you or a family member or an embryo lawfully held by you or a family member receiving assistive reproductive services.

I authorize PMA Companies, my Employer, and their representatives and agents to communicate directly both orally and in writing with all treating physicians or medical providers of any kind regarding all facts and opinions relevant to my claim. I authorize any treating physician or other medical provider to communicate directly both orally and in writing with PMA Companies, my Employer, and their representatives and agents, concerning all aspects of my treatment for the illness or injury for which I am receiving or seeking benefits.

I also authorize the Social Security Administration to release to PMA Companies information concerning entitlement dates and benefit amounts for myself and my dependents.

I further authorize PMA Companies to release any such medical information to its reinsurers, attorneys, medical peer review panels, state insurance or fraud agencies, managed care vendors and their vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that PMA Companies consider doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand the information released to PMA Companies as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing, this authorization shall be valid for twenty-four (24) months from the date listed below. A copy of this authorization is to be considered as valid as the original.

Signature: _____

Printed Name: _____

Date: _____