Supervisor Workers' Compensation Instructions

When an employee gets hurt on the job, please follow these steps:

1. Assess the situation. Does the employee need to go to the doctor?
    a. If the employee needs to see a doctor, call University Medical Specialties (269-473-2222) and inform them that the employee will be arriving for treatment.

        NOTE: When the employee goes to University Medical Specialties, they MUST inform the medical center that this is a Workers' Compensation case. If the employee chooses not to go to University Medical Specialties and/or does not inform them their injury is work related, then payment under Workers' Compensation insurance can be refused. If the employee is hurt after University Medical Specialties hours, an on-call doctor can be reached by calling 269-473-2222. The option of the walk-in clinic or emergency room is also available but only in case of life-threatening situations.

    b. If the employee does not need medical attention, administer first aid, if necessary, and follow steps 3 and 4.
2. As soon as possible, call Workers' Compensation (269-471-3886) and relate the situation and action being taken.
3. Fill out the supervisor's report (SARF) on line at: http://www.andrews.edu/HR/documents/sarf.pdf
4. Submit completed form to both the Workers' Compensation office and the Office of Campus Safety.
5. If the doctor informs the employee that work needs to be missed or restricted because of the work related injury or illness, any paperwork from the doctor to indicate missed or restricted work **MUST** be forwarded to the Workers' Compensation office.
6. If an employee has missed any work due to the work related injury or illnesses please contact the Workers' Compensation office **before** submitting time to Payroll.
7. Each day/week that the employee is out of work needs to correspond directly with a doctor's order for the missed/restricted work. Any note, bills, or correspondence from or to the doctor or employee **MUST** be forwarded to the Workers' Compensation office.
8. When the employee is ready to return to work or released from restricted duty; the employee must provide a return to work (RTW) note from their doctor. The RTW **MUST** be forwarded the Workers' Compensation office.

Please inform the Workers' Compensation office of any changes in the employee's situation or condition as soon as possible.

Your assistance aids both the Workers' Compensation office as well as the employee in returning to normal work conditions quickly.

Thank you,

Workers' Compensation Office
Human Resources – 0840
Tele 269-471-3886
Fax 269-471-6293
workcomp@andrews.edu

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Office Of Human Resources **Supervisor Accident Report Form**

Handling Instructions

This form is to be completed in response to an injury or a near miss accident that affected an Andrews University employee.

The information in this completed form contains private information and should be considered peronsal and confidential. This form, once completed, should only be handled by the supervisor of the injured employee and should be submitted directly to the Office of Human Resources and the Office of Campus Safety.

Form Completion Glossary

Date of injury: Date of employee's injury

Location: Where the employee was when they were injured

Employee name: Name of injured employee

Supervisor name: Name of employee's supervisor

Accident Type: If employee was treated, click on the pre-selected response, ***Injury*** . If they were not treated, click on the pre-selected response, ***Near Miss – No injury*** .

Date injury reported: Date when the employee reported the accident to their supervisor.

Was the employee clocked in at the time of injury? Auto filled for hourly, if they clocked-in. Y/N for a salaried employee.

Was the employee performing a work related function at the time of injury? Was the task a normal function of their position

Where was the employee injured (anatomical location)? Part of body affected by injury

What was the type of injury? Use the pre-selected responses to identify the type of injury the employee sustained.

What was the extent of the injury? Use the pre-selected responses to identify the extent of injury the employee sustained.

What substance/object directly harmed/injured the employee? What caused the injury.

How was the employee injured? What the employee was doing when the injury occurred.

Did anyone witness the accident? If someone observed the accident/injury.

Witness name: Name of person who witnessed the accident when it occurred.

Additional Information

For additional instructions regarding worker's compensation and the role of a supervisor please go to the following website:
www.andrews.edu/services/hr/documents/workcomp/swcinstructions.pdf

If an employee's injuries result in the death of the employee, the Office of Human Resources must be alerted immediately (or the Office Of Campus Safety after business hours).

Contact Information

The Office Of Human Resources can be reached by phone at 269-471-3886 or by email at workcomp@andrews.edu

The Office Of Human Resources website can be found at: www.andrews.edu/hr

The Office Of Campus Safety can be reached by phone at 269-471-3321 or by email at safety@andrews.edu

The Office Of Campus Safety's website can be found at: www.andrews.edu/safety

The MIOSHA 24hr. Fatality Hotline can be reached by phone at 1-800-858-0397

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Office Of Human Resources **Supervisor Accident Report Form**

General

Date of Injury: **Time of Injury:** **Location:**

Injured Employee

Employee Name: **AUID#:** **DOB:**

Gender: F **Local Phone:** **Classification:** Classification

Department of Employment: **Job Title:** **Years In Position:**

Reporting Supervisor

Supervisor Name: **AUID#:** **DOB:**

Local Phone: **Supervisory Level:** Supervisor Level

Department of Employment: **Job Title:**

Did the Reporting Supervisor Witness the Accident? ○ Yes ○ No ○ N/A

Injury

Accident Type: Accident Type **Date Injury Reported:**

Was the employee clocked in at the time of injury? ○ Yes ○ No ○ N/A

Was the employee performing a work related function at the time of injury? ○ Yes ○ No ○ N/A

Where was the employee injured (anatomical location)?

What was the type & extent of injury? 1 Type 2 Extent

What substance/object directly harmed/injured the employee?

How was the employee injured?

Did anyone else witness the accident? ○ Yes ○ No ○ N/A

Witness Name: **AUID#:** **DOB:**

Witness Local Phone:

Injury Analysis

Was the employee trained to perform the work-related task? ○ Yes ○ No ○ N/A

Was the employee performing the work-related task as they were trained? ○ Yes ○ No ○ N/A

Was the work-related function evaluated for any hazards? ○ Yes ○ No ○ N/A

Were safe guards provided to protect the employee from the hazards? ○ Yes ○ No ○ N/A

Was the work-related function evaluated for personal protective equipment (PPE)? ○ Yes ○ No ○ N/A

Was the employee equipped/supplied with required PPE? ○ Yes ○ No ○ N/A

Was the employee using the PPE at the time of the injury? ○ Yes ○ No ○ N/A

Reset Form

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Office Of Human Resources **Supervisor Accident Report Form**

Medical Treatment

Was Campus Safety contacted?	**Yes**	**No**	**N/A**
Was first aid provided?	**Yes**	**No**	**N/A**
Did the employee go to University Medical Center?	**Yes**	**No**	**N/A**
If so, what was the name of the treating physician?			
Was an ambulance requested?	**Yes**	**No**	**N/A**
Did the ambulance treat the employee?	**Yes**	**No**	**N/A**
Did the employee go to the Emergency Room?	**Yes**	**No**	**N/A**
What hospital did the employee go to?			

Miscellaneous

Did the employee resume work immediately after the accident?	**Yes**	**No**	**N/A**
Was anyone else injured?	**Yes**	**No**	**N/A**
If so, do they work for the same department?	**Yes**	**No**	**N/A**
Was an Accident Report Form completed for any additionally injured employee?	**Yes**	**No**	**N/A**
Were measures taken to prevent any future injury to the injured employee?	**Yes**	**No**	**N/A**

If so please describe the measures taken.

Were measures taken to prevent any future injury to other employees?	**Yes**	**No**	**N/A**

If so please describe the measures taken.

The form is to be filled out in its entirety. By submitting this form, the supervisor states that all the information contained in the form is accurate to the best of their knowledge.

Reset Form