



"Any employee who is injured on the job or develops health problems that are work related must immediately report them to their supervisor. Prompt and accurate reporting of all accidents to the supervisor is necessary to insure proper processing of claims."
(Staff Handbook, p. 10.2)

1. If you are injured on the job or develop a health problem that is work-related, you must report this information to your immediate supervisor, regardless of how insignificant the injury or health problem may seem to you at the time.
2. If the injury or health problem is deemed severe enough to require the attention of a physician, you will be sent to Student Health Services. If you prefer, you may see your own physician.
3. Your supervisor will complete the Departmental Accident Investigation report and forward it to your Superintendent for his review. The Superintendent will, in turn, forward the original to the Administrative Office with a copy to the Safety Coordinator. The Administrative Office will complete the Employee's First Report of Injury form and forward that form to the Employee Benefits Office (if you are seen at the Student Health Center, that office will complete the Employee's First Report of Injury form).
4. While at Student Health Services or your own physician's office, you need to obtain medical certification (a doctor's statement) indicating whether or not you are able to return to work. If you are able to return to work, you are to return to work, submit the medical certification to your immediate supervisor, and note the time you were off work obtaining medical attention on your Daily Time Card (white card). Your supervisor will note this time off on your clock card. If you are unable to return to work, you should have your physician send this medical certification to the Administrative Office, Department of Physical Plant, University of Louisville, Louisville, KY 40292. This certification must indicate the length of the anticipated inability to work.
5. When you return to work, you must present medical certification (a doctor's statement) stating that you are able to return to work. The Administrative office will complete a Return to Work form and forward it to the Employee Benefits Office.
6. Failure to promptly and accurately report an on-the-job injury or work-related health problem may result in over or under payment of benefits and possible disciplinary action as appropriate.



Accident Investigation Report
Physical Plant

Employee Information

Full Name: Last First M.I.

Address: Street Address Apartment/Unit #

City State Zip code

Home Phone: () Alternate Phone: ()

Social Security Number:

Birth Date: Marital Status:

Usual occupation: Group/Shop regularly employed:

Hours worked/day

Hours worked/week:

Days worked/week:

Date/Time of accident: Date/Time accident reported:

Severity of occurrence: (Fatality, Restricted Activity, Medical Treatment, First Aid)

Brief description of the nature of injury (include part of body injured):

Specific location of accident/occurrence:

On employer's premises? Yes / No

Name of others injured in the same accident/occurrence:

Did the injured require medical treatment? Yes / No

If yes, please provide the medical facility name and address:

Brief description of treatment:

Will there be any lost time due to this accident/occurrence? Yes / No

Number of days/hours off (if known)



Date lost time begins: _____

Describe how the accident occurred: _____

Accident Sequence: Describe in reverse order of the events preceding the injury. Starting with the accident/occurrence, move backwards in time and reconstruct what happened.

Injury event: _____

Accident event: _____

Preceding event #1: _____

Preceding event #2: _____

Preceding event #3: _____

Task and activity at the time of the accident/occurrence:

- General type of task: _____
- Specific activity: _____
- Employee was working: Alone / With Others
- Witnesses: _____

Posture of Employee: _____

Supervision at the time of accident/occurrence: Direct/ Indirect/ Not Supervised/ Supervision not feasible

Events and conditions that contributed to the accident/occurrence: _____

Corrective actions that have been or will be taken to prevent recurrence: _____

Comments: _____



Prepared by: _____
Title: _____
Shop/Group _____
Email Address: _____
Date: _____