University of Hawaii
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

_____ Home Phone: _____ Work Phone: _____
City State Zip

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

Date of Injury: _____ Time of Injury: _____ a.m./p.m. (circle)
mo day year

Time Began Work on Day of Injury: _____ a.m./p.m. (circle) Supervisor's Name: _____

Date Injury/Illness reported to Supervisor or WC Coordinator (College Personnel Officer): _____

Exact Address/Location where injury occurred: _____

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

_____

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

_____

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

Fully describe how, when and where the injury occurred (e.g., I was in Hawaii 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 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? No [ ] Yes [ ] 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 | E-Mail | 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.

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

Employee-Claimant Employment Information:

Position Title: _____ Date of State Hire: _____ Gender (circle): Male/Female

Payroll #: _____ BU: _____ Contract Type (circle): 9 /11/12 ERS Plan Type (circle): A0 A1 H0 H1 C0 Z0 Z1 B0 V0 R1

Type of Appointment (circle): Regular/Temporary/Casual/Emergency OR Part-Time (Hrs worked per week): _____

Employing Agency Code: 22-_____ Pay: $ _____ Base Monthly OR $ _____ Hourly

UH Payroll Account Code and % at time of injury:

_____	%	_____	%
_____	%	_____	%
_____	%	_____	%

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

_____

Within 8 hours of a Death or 24 hours of a Catastrophic Event, Supervisors/WC Coordinators are responsible to call the DLIR – HIOSH **AND** DLIR – DCD **AND** TRISTAR/ORM phone numbers (leave a voicemail message if no one answers) for the following events:

- DLIR – HIOSH within 8 hours of a death due to industrial injury or within 24 hours of work-related injury of 1 or more employees requiring in-patient hospitalization, amputation, loss of an eye, or property damage worth $25,000 or more **AND**
- DLIR - DCD within 48 hours of a death due to industrial injury **AND**
- TRISTAR and ORM immediately upon notification of a work-related death/catastrophic event of an injury of 1 or more employees requiring in-patient hospitalization, amputation, loss of an eye, or property damage worth $25,000

Death/Catastrophic Event? No___ Yes ___ Date of Death: _____ Date/Time UH Notified of Death: _____

Date and Time DLIR–HIOSH (#1-808-586-9102) Notified of Death: _____

Date and Time DLIR – DCD (#1-808-586-9161) Notified of Death: _____

Date and Time TRISTAR (#1-808-470-0860 ext. 5212/5115/5120) Notified of Death: _____

Date and Time ORM (#1-808-956-8893/1-808-956-7243) Notified of Death: _____

Provide the Employee's Name, Date of Injury/Illness, Date/Time of Death (if applicable), and details of the event if speaking with a person. If leaving a voicemail message for HIOSH/DCD, leave your name, phone number and a brief summary of what happened without the employee's name. If leaving a voicemail message for TRISTAR/ORM, leave the Employee's Name, Date of Injury/Illness, Date/Time of Death (if applicable), and available details of the event.

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 TRISTAR 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 TRISTAR by FileDrop to **tpa.support.fi@tristargroup.net** *by:*

_____	_____	_____	_____
Authorized WC coordinator (print)	WC Coordinator Signature	Phone No.	Date

FileDrop to: TRISTAR (CentralServicesWC.FNOL@tristargroup.net) *and* ORM–WC (suzette@hawaii.edu)
Original: WC Coordinator (do not file in employee's personnel folder)