# SUPERVISOR'S
# CHECK LIST

**Supervisor**

**Employee Name: _____ Date: _____**

**Department: _____**

**Employee #:_____**

☐ **New Injury ____ Recurrence ____**

☐ **WC 207 First Report of Injury Form**

☐ **WC 207-1 Supervisor Accident Report**

☐ **Notified the Office of Human Resources on_____.**
**(Date)**

☐ **Employee received Worker's Compensation reporting packet**

**Supervisor Name: _____**

**Return this packet to Francesca Poole in the Office of Human Resources. Retain a copy for your file.**

Print Form

# DAS

# First Report of Injury WC 207

Reference No:

Central Office use only:
Incident No:

Claim No:

The Supervisor must complete this form with the employee and then forward it to your Agency's Worker's Compensation Specialist within 24 hours after the incident.

| | | | |
|---|---|---|---|
| 1. AgencyLocationCode<br>CSU 85000 | 2. Division/Region<br>Southern Connecticut State University - Department of _____ | | |
| 3.SSN | 4.Employee Number | 5.Name of Injured Worker (First) (Last) (MI) | |
| 6.Home Address (City or Town) (State) (Zip) | 7.Home Telephone | 8.Date of Birth | 9.Sex |
| 10.Job Classification | 11. Date of Hire | 12.Date of Incident | 13.Time of Incident |
| 14.Time Employer Notified | 15.Date Employer Notified | 16. Was Injury Fatal? YES NO | 17. Date of Fatality |

18. How Did the Injury Occur?

| | | |
|---|---|---|
| 19. Type of Injury | 20. Body Part(s) Affected | 21. Category of illness or Injury |
| 22. Did Injury Occur on Employer Premises? ☐ YES ☐ NO | 23. Location Injury Occured | |
| 24. Injured Worker Seeking Medical Treatment<br>☐ YES if yes complete question 25 NO ☐ | 25. Medical Care Provided By: (Physician Name and Address) | |

26. Were There Any Witnesses to the Injury?
(If yes, give name, address and phone.)

27. To Whom Was Injury Reported? (Name) (Title)

28. **SUPERVISOR CONTACT INFO**
Please Print

Name:

Work Phone:

Best Time to Contact:

29. Signature of Supervisor (or other Designated Authority)

I HAVE REVIEWED THE ABOVE FORM FOR COMPLETENESS

SUPERVISORS REPORT ALL INJURIES - CALL 1-800-828-2717

Reviewed 4/2014

# Supervisor's Accident Investigation Report 207-1

***The Supervisor must complete this form with the employee and then forward it to the Human Resources office, along with the 207 report, within 24 hours after the incident.***

**GENERAL INFORMATION**

| Employee Name | Date of Incident | Location of Incident |
|---|---|---|
| Job Title | Time of Incident | Medical Treatment? ☐ ER ☐ First Aid ☐ None ☐ Walk-In ☐ Ambulance ☐ Other |
| Nature of Injury | | |

**INCIDENT DESCRIPTION:** _____

_____

_____

**TYPE OF INCIDENT: (check most appropriate, define other if checked)**

- ☐ Assault by public
- ☐ Caught in/on/between
- ☐ Shoved by or against an object
- ☐ Contact with heat/cold/chemical
- ☐ Motor Vehicle Accident
- ☐ Slip/Trip/Fall
- ☐ Lifting/Material Handling
- ☐ Foreign body in eye
- ☐ Cumulative trauma
- ☐ Repetitive motion
- ☐ Cut/laceration/puncture
- ☐ Exposure (air quality, etc.)
- ☐ Other

**CAUSES/CONTRIBUTING FACTORS** *Check all that apply*

**CONDITIONS**

- ☐ Hazardous process
- ☐ Weather conditions
- ☐ Equipment not available
- ☐ Poor housekeeping
- ☐ Equipment malfunction
- ☐ Ergonomic set-up
- ☐ Floor/ground condition
- ☐ Poor lighting
- ☐ Poor design
- ☐ Carpet/mat
- ☐ Chemicals/cleaning agents
- ☐ Improper PPE
- ☐ Lack of training

**BEHAVIORS**

- ☐ Failure to follow safety procedure
- ☐ Failure to use PPE
- ☐ Improper technique
- ☐ Using equipment unsafely
- ☐ Inappropriate dress or footwear
- ☐ Failure to obtain assistance
- ☐ Working at unsafe speed
- ☐ Performing task without knowledge/failure to ask
- ☐ Failure to recognize unsafe condition
- ☐ Not in scope of duties
- ☐ Unsafe body mechanics
- ☐ Employee attitude on safety
- ☐ Horseplay
- ☐ Failure to use lookout/tagout
- ☐ Inattention/disfunction
- ☐ Poor judgement responding to unsafe condition
- ☐ Other

**ACTION PLAN TO PREVENT RECURRENCE**

- ☐ Reinforce employee accountability for safety
- ☐ Monitor work practices
- ☐ Work orders written
- ☐ Maintenance work order written
- ☐ Procedures revised
- ☐ Referrals made
- ☐ Apply OSHA program and manuals
- ☐ Additional training
- ☐ Hepatitus B vaccine
- ☐ Renew bloodborne training
- ☐ Renew hazmat training
- ☐ Ergonomic set-up evaluation
- ☐ Air quality consultation
- ☐ MVA= ☐ Local or ☐ State Investigation
- ☐ Other

| MANAGER SIGNATURE: | PRINT NAME: | DATE: |
|---|---|---|
| SUPERVISOR SIGNATURE: | PRINT NAME: | DATE: |

*white copy - Agency* *pink copy - Agency Human Resources* *yellow copy - DAS Human Resources*

# EMPLOYEE'S
# CHECK LIST

## Processing a Reported Work Related Injury

**Employee**

**Name:**_____ **Date:**_____

**Department:**_____

**Employee #:**_____

D **(Check One) New Injury** ____ **Recurrence** ____

D **CO 715 Request for Use of Accrued Leave Form**

D **WCC 1A Filing Status and Exemption Form**

D **WC 211 Third Party Liability Form**

D **Worker Status Report – Physician signature required**

D **Submitted to Human Resources on (mm/dd/yyyy)**_____
**(Return this packet to Human Resources when completed.)**

**Southern Connecticut State University**
**Workers' Compensation**
**Wintergreen Building**
**501 Crescent Street**
**New Haven, CT 06515**

To: Injured Employee
From: Workers' Compensation Liaison

**Important Information Regarding Your Claim/Recurrence****

**Please be sure to answer all questions on each form completely, sign and date ALL forms. Payment cannot be made without the completion and signed submission of these forms.** Incomplete forms will delay processing your claim and may result in your pay being docked. Claim forms should be completed by you and your supervisor and sent to the SCSU Workers' Compensation Liaison* within 24 hours of your injury.

- ✓ Report injury immediately to your supervisor.
- ✓ Obtain your employee workers' compensation packet from your supervisor.
- ✓ Seek immediate treatment from the Hospital of St. Raphael's Occupational Health Plus, 175 Sherman Avenue, New Haven, CT. Be advised that your claim may not be accepted if you see a physician that has not been approved by the Third Party Administrator (TPA) – Gallagher Bassett Services Inc. Provider Network.
- ✓ After receiving medical treatment you will receive a Workers' Status Report from the Physician. **Copies of all medical reports and doctors visits including the Workers' Status Report must be forwarded to the SCSU Workers' Compensation Liaison* immediately after each visit. If you are unable to return to work due to your injury, you must contact your supervisor and SCSU's Workers' Compensation Liaison* immediately.**
- ✓ Complete and sign the DAS WC-715 (Request for Use of Accrued Leave Form). You must elect to use or not use accrued leave balances in accordance with General Letter No. 78.
- ✓ Complete and sign the 1A (Filing Status and Exemption Form).
- ✓ Complete and sign the WC-211 (Concurrent Employment and Third Party Liability).
- ✓ Include a completed incident report if injury was reported to University Police or University Health Office.
- ✓ While on an extended workers' compensation absence from work you must substantiate your leave by regularly providing up to date medical reports to the SCSU's Workers' Compensation Liaison*; and reporting accordingly with your supervisor.
- ✓ **Never complete or sign a WC-207**. This form is to be completed by your supervisor. When this form is complete, be sure to ask for a copy for your records and the original must be returned to SCSU's Workers' Compensation Liaison*.
- ✓ Contact your Workers' Compensation Liaison* immediately when your doctor has cleared you to return to work and prior to your arriving at your department.

**If your absence from work is due to a recurrence, you must contact your supervisor and the SCSU WC Liaison immediately. Recurrence claims must be supported by relating medical documentation to be considered for approval by the Third Party Administrator. Recurrences must be reported to Gallagher Bassett Services by your supervisor by calling 1-860256-3440 and the SCSU WC Liaison. Employees under no circumstances should be reporting their own claim to Gallagher Bassett Services. If your claim is a recurrence, then you are responsible for providing all documentation again as stated above.

**Your claim will not be set up until all information is received by the Workers' Compensation Liaison.**

*SCSU Worker's Compensation Liaison: Francesca Poole (203) 392-5059

# Request for Use of Accrued Leave with Workers' Compensation

# DAS WC-715

3-10

This form covers an employee election to utilize or not utilize accrued leave (existing balances and additional accruals as credited) during the interim period and/or to supplement lost wage benefits on an approved workers' compensation claim. The Agency Section shall be completed with the initial agency processing of the **LOST TIME** claim and provided to the injured employee with instruction to make an election and ***RETURN WITHIN 10 BUSINESS DAYS***. This form is to be maintained in the injured worker's agency workers' compensation file.

**AGENCY SECTION**

| Agency Name | Department ID |
|---|---|
| | |

| Employee Name | Employee ID |
|---|---|
| | |

| Date of Injury | Daily Pay Rate | **LEAVE BALANCES** As of date of injury Denoted in Hours | Sick | Vacation | Personal | Holiday Comp | Comp |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**EMPLOYEE ELECTION SECTION** - Please check your choice of the options available to you then sign and return to your agency Workers' Compensation office **within ten business days.** Failure to return the completed form to the agency will be administered as an election **not** to utilize accrued leave during the interim period and **not** to supplement the approved workers' compensation lost wage benefit.

## USE OF ACCRUED LEAVE FOR INTERIM PERIOD

☐ I elect NOT to use accrued leave during the interim period (after the first day of my incapacity and continuing until such time as a determination of compensation is made).

☐ I elect to use accrued leave during this interim period. By choosing this option I will receive my full base pay while a determination of compensation is being made. I understand that, once a compensation award has been made, I must repay the State an amount equal to the net pay I would have received during such interim period in order for my leave balances to be restored. I further understand that sick leave must be used first, followed by my designated choice of vacation, personal, holiday compensatory time and/or compensatory leave, as designated below.

| Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2,3,4,5 in each box: | Sick 1 | Vacation | Personal | Holiday Comp | Compensatory |
|---|---|---|---|---|---|

## USE OF ACCRUED LEAVE WHILE RECEIVING WORKERS' COMPENSATION

☐ I elect NOT to use any of my accrued leave while I am receiving Workers' Compensation lost wage benefits.

☐ I elect to use accrued leave, which in addition to the lost wage benefits awarded to me under Workers' Compensation, will result in my receiving the equivalent of my full base pay while I am receiving Workers' Compensation lost wage benefits. I further understand that sick leave must be used first, followed by vacation and/or personal leave, as designated below.

| Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2 or 3 in each box: | Sick 1 | Vacation | Personal |
|---|---|---|---|

## STATEMENT OF APPLICANT

**I have read and understand the above explanation of the choices available to me as a result of my application for workers' compensation.** Once made, this election cannot be revoked and will remain in effect until all accrued leave (including any future accruals that may be credited to me) is exhausted or until I return to my pre-injury number of scheduled work hours. **I agree to the conditions applicable to the choices I have checked above.**

**SIGNATURE OF EMPLOYEE** **DATE SIGNED**

# Southern Connecticut State University

## WC - 211 Concurrent Employment Third Party Liability Form

Per WC-211 Rev. 2/05

## EMPLOYEE TO COMPLETE

| | |
|---|---|
| Employee Name (last) (First) (MI) | Social Security Number |
| Address (No. and Street) | Telephone Number |
| City or Town | Date of Injury |
| Employing State Agency: Southern Connecticut State University | Date of Birth |
| Address of Employing Agency (No. and Street): 501 Crescent Street New Haven, CT Zip: 06515 | Date First Employed by State |

## EMPLOYEE INSTRUCTIONS

The information requested on concurrent employment below is necessary to determine your Workers' compensation benefit rate:

1. You must complete this form for every Workers' Compensation claim you file.
2. You must keep the information contained in this form current while you are receiving Workers' Compensation benefits.
3. You must return this form to your personnel office within three days.

Note: If your claim is for Temporary Total or Temporary Partial disability benefits, you must advise your employer of any other earnings while receiving these benefits. Failure to do so may result in civil and/or criminal liability.

## CONCURRENT EMPLOYMENT

CHECK IF ANY OF THE FOLLOWING APPLY: ☐ NONE

☐ Employed by Another State Agency ☐ Employed Outside State Government

| | | |
|---|---|---|
| Name of Other Employer | Supervisor's Name | Telephone Number of Employer |
| Address of Employer (No. and Street) | City or Town | State Zip |

## THIRD PARTY LIABILITY INFORMATION

1. Was the cause of your accident/injury the result of the actions of a party other than you or your employer?

   Yes ☐ No ☐

   If you checked yes, please describe the facts.

   Name the Third Party _____

   Address _____

   Insurance Carrier of Third Party _____

2. Were there any witnesses?

   Yes ☐ No ☐

   Name of witnesses _____

3. Have you initiated a claim against this responsible Third party?

   Yes ☐ No ☐ Date _____

I DECLARE THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AM AWARE THAT PROVIDING FALSE INFORMATION MAY RESULT IN CIVIL, OR CRIMINAL LIABILITY.

Signature _____ Date _____

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 3-17-2006

# 1A

# Filing Status and Exemption

**This form must be executed in every case of compensable disability for injuries occurring ON OR AFTER October 1, 1991, and must be completed in its entirety.**

**WCC File #**

**Date filed in District**

(for WCC use only)

**EMPLOYEE**

Name _____ Soc. Sec.# *(optional)* _____

Address _____

City/Town _____ State _____ Zip Code _____

**FILING STATUS AND EXEMPTIONS — In order to determine your weekly benefit rate, as per Sec. 31-310 C.G.S., we need the following information:**

**DATE OF INJURY:** _____

**The Filing Status and Exemption(s) indicated at left MUST reflect employee's Federal tax status for the Date of Injury provided here.**

1. Select your Federal tax filing status based upon your ACTUAL filing status as of the date of injury listed at right:
   ☐ Single ☐ Head of Household ☐ Married filing jointly ☐ Married filing separately
2. Number of exemptions *(including yourself)* as of the date of injury listed at right = _____
3. Check all appropriate boxes:
   ☐ Employee 65 years of age or older ☐ Employee legally blind ☐ Spouse 65 years of age or older ☐ Spouse legally blind
4. FICA withheld for the above-named employee? ..... ☐ YES ..... ☐ NO — ***If NO, Insurer must manually calculate weekly benefit rate.***
5. List name *(yourself first)*, date of birth, and relationship to you for all exemptions included in question #2, above:

| *Name* | *Date of Birth* | *Relationship* |
|---|---|---|
| | | **SELF** |
| | | |
| | | |
| | | |
| | | |
| | | |

**CONCURRENT EMPLOYMENT — To be certain you receive all the benefits to which you are entitled, provide the following information *if you were working for more than one employer on the date of injury indicated above*:**

| *Name of Employer* | *Address* | *Date of Hire* |
|---|---|---|
| | | |
| | | |
| | | |

NOTE: Wage information for each concurrent employer must be supplied by the claimant.

**SIGNATURE OF INJURED WORKER OR REPRESENTATIVE**

**WARNING: Any person who intentionally misrepresents or fails to disclose any material fact related to a claimed injury may be guilty of a felony.**

Employee's Signature _____ Date _____