Accident Investigation and Reporting Program
Required Forms
Instructions and Guidance

This document contains multiple forms that must be completed for all employee accidents, illnesses or injuries. The purpose of these forms is to ensure compliance with the State of Delaware Workers' Compensation Laws, ensure proper payment of medical bills and to provide Environmental Health and Safety (EHS) with the necessary information to investigate the accident.

There are four separate forms that may be required:

Form #1: State of Delaware First Report of Occupational Injury or Disease. Contact Labor Relations at 302-831-8305 if you have questions or need assistance with this form.

- This form must be completed for all accidents, injuries and illnesses regardless of medical treatment. The form will be used to ensure payment of medical bills or salary due to lost time.
- This form is included below.
- Send this completed form to Labor Relations

Form #2: University of Delaware Illness/Injury Loss Investigation Report. Contact EHS at 302-831-8475 if you have questions or need assistance with this form.

- This form must be completed for all accidents, injuries and illnesses regardless of medical treatment. The form is initially completed by the supervisor and sent to EHS. EHS will use the data gathered in the form to complete an accident investigation.
- Send this completed form to Supervisor, Safety Chair, Environmental Health and Safety, Labor Relations
- This form is included below.

Form #3: State of Delaware Workers' Compensation Employer's Modified Duty Availability Report. Contact Labor Relations at 302-831-8305 if you have questions or need assistance with this form.

- The form is completed if the employee receives medical treatment for the injury or illness.
- This form is completed by the supervisor after she/he reviews the work restrictions listed in the Physician's Report of Workers Compensation Injury. The supervisor will outline how the employee's job functions will be changed to accommodate the treating physician's work restrictions. The completed form must be sent to the treating physician for approval of the work accommodations.
- Send this completed form to Labor Relations
- This form is included below. It is also available online.
- http://dowc.ingenix.com/docs/05-09%20Revisions%20Employer%20FORMS.doc

Form #4: State of Delaware Workers' Compensation Physician's Report of Workers Compensation Injury. Contact Labor Relations at 302-831-8305 if you have questions or need assistance with this form.

- This form must be completed by the treating physician and outlines any work restrictions required due to the injury or illness. The physician will send the form to the employee and the employer within 14 days of treatment. It is recommended that the supervisor send the approved job description to the treating physician for review.
- This form is currently available online as a PDF document.
- http://dowc.ingenix.com/docs/10-09%20FORMS%20-%20Physician%202009%2010-21.pdf

Form #1: State of Delaware First Report of Occupational Injury or Disease

Contact Labor Relations at 302-831-8305 if you have questions or need assistance with this form.

ALL COPIES OF FIRST REPORT MUST BE TYPED OR PRINTED

Department of Labor
Office of Worker's Compensation
P.O. Box 8902
Wilmington, DE 19899-8902
Telephone: 302-761-8200

STATE OF DELAWARE FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

CASE OR FILE NO.

LOCATION/DEPT. CODE
90 / 01000

EMPLOYER'S UC REPORTING NUMBER

EMPLOYEE

1.. EMPLOYEE: FIRST MIDDLE LAST

2. EMPLOYEE SOCIAL SECURITY NO. - -

3. ADDRESS – INCLUDE COUNTY AND ZIP CODE

4. MALE ☐ FEMALE ☐

5. EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE) - -

6. . DATE OF BIRTH - -

7. AGE

8. WAGE

9. WEEKLY HOURS WORKED

10. OCCUPATION (REGULAR)

11. DEPARTMENT OF DIVISION REGULARLY EMPLOYED

12. HOW LONG EMPLOYED

EMPLOYER

13.. EMPLOYER
University of Delaware

14. PERSON MAKING OUT THIS REPORT
Juanita S. Crook, Administrative Assistant

15. ADDRESS – INCLUDE COUNTY AND ZIP CODE
413 Academy St. Newark DE 19716

16. EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE)
302-831-8305

17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE

18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC.
Educational Institute

DATES

19. DATE OF REPORT - -

20. DATE OF INJURY AND TIME - - ☐ AM ☐ PM

21. NORMAL STARTING TIME ☐ AM ☐ PM,

22. IF EMPLOYEE BACK TO WORK GIVE DATE - -

23. AT SAME WAGE YES ☐ NO ☐

24. IF FATAL INJURY, GIVE DATE OF DEATH. - -

25. DATE EMPLOYER KNEW OF INJURY - -

26. DATE DISABILITY BEGAN - -

27. LAST FULL DAY PAID – DATE -- -

INJURY OR DISEASE

28. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.

29. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.

OCCURRENCE

30.. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE WAS USING WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.

31. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, I.E.

32. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED

33. NAME OF PHYSICIAN

34. PHYSICIAN'S ADDRESS

35. HOSPITAL (IF APPLICABLE)

36. HOSPITAL ADDRESS

WORKER'S COMPENSATION INSURANCE COMPANY AND COMPLETE ADDRESS (PREPRINT OR STAMP INCLUDE IAB CODE)
37. (THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS.)

PMA Management Corp
P O Box 25250 Lehigh Valley, PA 18002

I.A.B. CODE 40
POLICY NO. 2909007621402

DISTRIBUTION OF THIS REPORT

1. **ORIGINAL MUST BE SENT IMMEDIATELY TO WORKER'S COMPENSATION INSURANCE CARRIER.**
2. **COPY TO INDUSTRIAL ACCIDENT BOARD**
3. **EMPLOYER'S COPY – RETAIN AS RECORD**
4. **EMPLOYEE'S COPY**

jsc
SIGNATURE OF PERSON IN 14 ABOVE

OFFICIAL POSITION

DOC. NO. #60-07-01-90-10-0

Form #2: University of Delaware Illness/Injury Loss Investigation Report

Contact EHS at 302-831-8475 if you have questions or need assistance with this form.

Rejected: Yes ☐ No ☐ Rejected By: _____

Date: _____ Reason: _____

CASE NO:	***UNIVERSITY OF DELAWARE ILLNESS/INJURY LOSS INVESTIGATION REPORT***		
DATE OF INJURY/ILLNESS/LOSS:	*NAME OF INJURED:*	*INJURED PERSON'S DEPARTMENT:*	*IMMEDIATE SUPERVISOR:*

IDENTIFY THE DIRECT AND CONTRIBUTING CAUSES OF THE ILLNESS/INJURY

1. Was the employee made aware of hazards and proper safety procedures associated with the task prior to the accident? (Explain)

2. What mechanical, physical or environmental conditions contributed to the accident (broken equipment, poor lighting, noise, material defects, slippery surfaces, lack of warning signs or posted directions, etc.)?

3. What act(s) by the injured and/or others contributed to the accident (wrong tool or equipment, improper position or placement, work rule violation, failed to follow instructions, etc.)?

4. What personal factors contributed to the accident (improper attitude, fatigue, inattention, substance abuse, etc.)?

5. Was the accident the result of failing to wear personal protective equipment? (Explain)
6. What corrective action(s) has been or will be taken to prevent a recurrence of this type of accident (repair/modify/replace equipment, counseling, training, policies, procedures, etc.)?
7. Who is responsible to implement correction actions?

INVESTIGATED BY: Supervisor	DATE:	REVIEWED BY: Safety Committee Chair	DATE:

ENVIRONMENTAL HEATH & SAFETY USE ONLY

Routing:1. Supervisor, 2. Safety Chair, 3. Environmental Health and Safety, 4. Labor Relations

Form #3: State of Delaware Workers' Compensation Employer's Modified Duty Availability Report

Contact Labor Relations at 302-831-8305 if you have questions or need assistance with this form.

EMPLOYER'S FORM
INSTRUCTIONS/DEFINITIONS

The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury.

Complete all applicable fields.

1. Case Information:

- **Employer Name:** The name of the employer associated with the claim.
- **Employee Name:** Name of the injured worker.
- **Modification Duty Information:** Complete all applicable fields
- **Employer Fax:** The telephone and fax numbers of the employer.
- **Job Title:** Provide job title for position available.
- **Job Description:** Provide description of physical requirements of job duties for position available.
- **Environment/Working Conditions:** Identify any environmental factors relevant to position available.

2. Hours Per Day Job Available: Circle the number of hours applicable.

3. Additional Information: Circle the applicable work status categories for the position available, and comment as appropriate in the space provided regarding the work postures/positional requirements for the modified duty job available.

4. Employer: Provide job availability date.

5. Comments: To be used to explain/clarify any information required by this form.

6. Employer Information: The person responsible for completing this form on behalf of the employer must sign and date this form.

WITHIN FOURTEEN (14) DAYS OF RECEIVING A NOTICE OF INJURY, THE EMPLOYER SHALL PROVIDE THIS FORM TO THE INJURED WORKER'S HEALTH CARE PROVIDER/PHYSICIAN AND THE EMPLOYER'S INSURANCE CARRIER AS REQUIRED BY 19 DEL.C. §2322E(d).

THE HEALTH CARE PROVIDER/PHYSICIAN MUST COMPLETE HIS/HER PORTION OF THIS FORM AND SIGN AND RETURN IT TO THE EMPLOYER WITHIN FOURTEEN (14) DAYS OF THE NEXT DATE OF SERVICE AFTER THE PHYSICIAN'S RECEIPT OF THE FORM FROM THE EMPLOYER, BUT NOT LATER THAN TWENTY-ONE (21) DAYS FROM THE PHYSICIAN'S RECEIPT OF SUCH FORM.

DELAWARE WORKERS' COMPENSATION
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE:

EMPLOYER: EMPLOYEE:

IS MODIFIED DUTY AVAILABLE: Yes No EMPLOYER FAX #:

IF AVAILABLE, FOR WHAT PERIOD OF TIME: Weeks Indefinite

JOB TITLE:

JOB DESCRIPTION:

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature):

Hrs. per day job available: (circle minimum and maximum) 8 6 4 2 0

D.O.T. Classification of Work (Circle one)

Sedentary Exerting up to 10 lbs. of force *occasionally* and/or a negligible amount of force *frequently* to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

Light Exerting up to 20 lbs. of force *occasionally* and/or up to 10 lbs. of force *frequently* and/or negligible amount of force *constantly* to move objects. Physical demand requirements are in excess of those for Sedentary Work.

Medium Exerting 20 to 50 lbs. of force *occasionally* and/or 10 to 25 lbs. of force *frequently* and or greater than negligible up to 10 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Light Work.

Heavy Exerting 50 to 100 lbs. of force *occasionally* and/or 25 to 50 lbs. of force *frequently* and/or 10 to 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Medium Work.

Very Heavy Exerting in excess of 100 lbs. of force *occasionally* and/or in excess of 50 lbs. of force *frequently* and/or in excess of 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Heavy Work.

Definitions:
Occasionally: activity or condition exists up to 1/3 of the time
Frequently: activity or condition exists from 1/3 to 2/3 of the time
Constantly: activity or condition exists 2/3 or more of the time

Work Postures/Positional requirements: Comment **as appropriate** in the space provided regarding the following Postures/Positions for the modified duty job available.

Sitting: Squatting: Standing:

Crawling: Walking: Climbing:

Driving: Repeated arm motions: Bending:

Turn/Twist: Kneeling: Foot controls:

Reaching up above shoulder: Repetitive use of wrist/hands:

Comments:

EMPLOYER: Date job is available:

Comments:

Employer Signature:_____ Date:

PHYSICIAN: I approve the job described above. ( ) Yes. ( ) No.
If no, reasons for disapproval/recommended modifications:

Physician Signature:_____ Date:

Physician Name (Please print): Certified provider: YES NO

The Health Care Provider/Physician MUST complete his/her portion of this form and SIGN and RETURN it to the EMPLOYER within fourteen (14) days of the next date of service after the HC Provider/Physician's receipt of the form from the employer, but not later than twenty-one (21) days from the HC Provider/Physician's receipt off such form.