Cannon Cochran Management Services, Inc. (CCMSI)
100 Quannapowitt Parkway, Suite 201
Wakefield, MA 01880
Fax (781) 246-3425

Accident Report

OSHA Form 301
Please print clearly or type

For Office Use Only
Claim #:
Priors: YES ☐ NO ☐

CCMSI (781)-683-1000

TO BE COMPLETED BY INJURED EMPLOYEE

Name _____ Home Telephone Number ( ) _____

Home Address _____ Work Telephone Number ( ) _____

City _____ State _____ Zip _____ Date of Birth / / Harvard ID Number _____

Date of Injury / /	Time Shift Started _____ am/pm	Time Shift Ended _____ am/pm	Time of Injury _____ am/pm ☐ Check if cannot be determined	Gender ☐ Male ☐ Female

Building (example: Holyoke Center or Gordon Hall) _____

Specific location where injury occurred _____

What were you doing immediately prior to the injury? *[Describe the activity, as well as the tools, equipment, or material being used. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."]*

What Happened? Tell us how the injury occurred. *[Examples: "When ladder slipped on wet floor, fell 20 feet"; "Developed soreness in wrist over time."]*

What object, substance or motion directly injured you? *[Examples: "concrete floor"; "chlorine"; "radial arm saw."* If this question does not apply to the incident, leave it blank.]

What was the injury or illness? [*Tell us the part of the body that was affected and how it was affected. Examples: "strained back"; "chemical burn, right hand"; "carpal tunnel syndrome."]*

Could this injury result in HIV infection? ☐ Yes ☐ No *[To be eligible for the HIV Benefit Plan, all work-related incidents that could result in HIV infection must be called into the Disability Claims Unit (495-9054) and followed by authorized HIV blood testing within 5 calendar days of the incident.]*

Information about the physician or other health care professional

Doctor/Hospital _____

Address

City _____ State _____ Zip _____

Witness 1. Name: _____

Telephone #: ( ) _____

Witness 2. Name: _____

Telephone #: ( ) _____

Signature of injured employee _____ Today's Date / /

TO BE COMPLETED BY THE SUPERVISOR TO WHOM THIS INJURY WAS REPORTED

Has employee lost more than 4 hours from work as a result of this alleged injury? ☐ No ☐ Yes ☐ Unknown

If yes, submit current job description & list dates out _____ Has employee returned to work? ☐ No ☐ Yes, on _____

Date you first knew employee was allegedly injured at work? / / If employee died, when did death occur? Date of death / /

Print Name _____ Telephone Number ( ) _____

Signature _____ Today's Date / /

TO BE COMPLETED BY DEPARTMENT

33 Digit Payroll Code

TUB	ORG	OBJECT*	FUND	ACTIVITY	SUB-ACT	ROOT

*Object code required

Department Name and Unit _____

Address of Department (including city) _____

Employee's Job Title _____ Date of Hire / / Union Code _____

Scheduled # of hours/week _____ Scheduled days off _____

Pay Rate: $ _____ /hour Blended Rate? (check if yes) ☐ Multiple Jobs? (check if yes) ☐

Payroll Coordinator _____ Telephone Number ( ) _____

This section completed by (print name) _____ Telephone Number ( ) _____

Signature _____ Today's Date / /