Appalachian State University EMPLOYEE INCIDENT REPORT

Appalachian STATE UNIVERSITY
BOONE, NORTH CAROLINA

Instructions: Employee must complete report. If more room is needed, continue in a Word document and attach it to this submission.

Employees are required to complete this form for all incidents and near hits. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

Supervisor Review: If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report.

My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Check ☐ Not applicable (employee completed form) or sign below if you assisted with the completion of this form.

Supervisor Name: Signature:

Employee Information			Date/Location Information	
Name (Full):			Date of Incident: / /	Time of Day:
Employee ID #:			Date Reported to Supervisor: / /	Time employee began work:
Job Title:		☐ Male ☐ Female	Home Address:	
Telephone #:				
Department:			Incident Location (address, Building name, office, cross streets, fire name, woods, facility, room #, etc.):	
Supervisor:	Phone #:			
Date Hired:	Time in Current Job:		County:	

Witness Information

Were there any witnesses to the incident? ☐ Yes ☐ No Number of Witnesses (if applicable): _____

If yes, list all known witnesses/phone #'s below, please include additional names on attachment if needed.

Name: Phone #:

Name: Phone #:

Medical Information

Part(s) of the body injured:

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? ☐ Yes ☐ No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

Description of Accident/Incident

What was the root cause of the incident? Ask why, and then ask why again. (e.g. Why? I slipped on scrap metal. Why? The work area was not cleaned up. Why? I was rushing to get project done and did not take time to clean up the work area.)

Suggested Corrective Actions

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Employee Name Signature Date / /

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EMPLOYEE RELEASE OF INFORMATION

MEDICAL AND CLAIM RECORDS

To Whom It May Concern:

My employer filed an Employer's Report of Employee's Injury to the North Carolina Industrial Commission (Form 19) for an injury I reported that occurred on _____.
(insert date of injury)

My employer participates in the North Carolina State Government Workers' Compensation Program administered by the NC Office of State Human Resources.

I understand that claim examination and claim processing procedures shall require release of certain information regarding this claim for distribution, as necessary, to the North Carolina Industrial Commission, state contractors, agencies, healthcare providers and other individuals.

Therefore, I hereby authorize release of any and all information for review, examination, copying and distribution regarding:

Pre-existing or current medical/mental health condition(s), pre-existing or current medical/mental health treatment(s), or any other medical/mental health treatment related to this claim.

1. Any previous workers' compensation injuries or claims whether reported or not to the North Carolina Industrial Commission, or any other State or Federal agency.

I understand state contractors, agencies, healthcare providers and other individuals may communicate this information by any reasonable means, including written or telephonic communication or by direct interview, whether or not I am present during or notified of such communications, and I authorize, to initiate and conduct such communications whether or not I am present or have notice thereof.

I understand that this information will be kept strictly confidential unless legal requirements necessitate its release and will be gathered solely for purposes related to this workers' compensation claim.

An electronic of faxed copy of this document shall have the same effect as the original.

Employee Name (Print)	**Employing Agency**
Employee Signature	**Supervisor or Witness Signature**
Date	**Date**

Please send records to:
Appalachian State University
Human Resources / Leave Management Administrator
Carolyn Bosley
ASU Box 32010
Boone, NC 28608
828-262-6488 phone
828-262-6489 fax

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EMPLOYEE USE OF LEAVE OPTIONS FORM

The following leave options are available during the seven (7) day waiting period to receive temporary total disability (TTD) benefits for an injured employee that loses time from work as a result of an on-the-job injury that is determined by their employing agency to be compensable.

Check one of the options below to elect leave usage for the seven (7) day waiting period.

- ☐ **Option 1:** Elect to take sick or vacation leave during the required seven-day waiting period and then go on workers' compensation leave and begin drawing workers' compensation weekly benefits.
- ☐ **Option 2:** Elect leave without pay for the seven-day waiting period and then began drawing workers' compensation weekly benefits.

Note: In either option above if the injury results in disability of more than 21 days, the workers' compensation weekly benefit shall be allowed from the date of the disability.

Check one of the options below to elect the option to supplement workers' compensation payments after the seven (7) day waiting period.

- ☐ **Option 1:** Elect to supplement the workers' compensation weekly benefit with the use of partial earned sick or vacation leave in accordance with the schedule provided by the Office of State Human Resources. Use of the supplemental leave benefit applies only while drawing temporary total disability compensation.
- ☐ **Option 2:** Elect workers' compensation payments without supplemental leave usage.

Note: All elections involving use of earned sick or vacation leave are subject to their availability at the time of the injury.

By signing below, I certify that in the event of any overpayment of wages or workers' compensation benefits, such amounts shall be deducted from future benefits owed or immediately repaid in cash by the employee. This election may only be changed by completing a new form.

Employee Name (print)	Date of Injury
Employing Agency	Division/Unit
Employee Signature	Date

Supervisor Completes This Section

The above named employee was injured on _____ (Date of Injury) and was placed on workers' compensation leave effective _____ (Date of Disability). I completed an Incident Investigation Report for this injury and submitted it to my agency's workers' compensation administrator along with all information necessary to complete the Industrial Commission Form 19, Employer's Report of Employee's Injury of Occupational Disease to the Industrial Commission.

Supervisor Name (print)	Title
Supervisor Signature	Date