Utah law requires notice that Workers' Compensation fraud is a crime. Please see the 2nd page for the full fraud statement.

Risk Management & Safety Dept.
SUPERVISOR'S INCIDENT INVESTIGATION REPORT
124 TOMH P.O. Box 20100
Provo, UT 84608-0100
(801) 422-3610
(For all BYU Personnel)

FOR OFFICE USE ONLY
☐ Entered _____ Case No.
☐ Incident Only ☐ Denied
☐ Approved _____ Auth. Init.

THE RECEIPT OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

SSN: _____ Full Name of Injured/Ill Individual: _____

Work Phone: _____ Home Phone: _____ Date of Birth: ___/___/_____

Local Address: _____ City: _____ State: ____ Zip: _____

Marital Status: _____ Sex: M / F (Circle One) No. of minor dependants under 18 Yrs. old: _____

In Case of Accident, Notify: _____ Relationship: _____

Job Title: _____ Job Status: ☐ Active ☐ Terminated

(Check One) Full-Time: ☐Staff ☐Admin. ☐Faculty Part-Time: ☐App. PT ☐Temp. ☐Student

Wage or Salary: _____ ☐Hour ☐Day ☐Month ☐Year Date Hired at BYU: ___/___/_____

Department: _____ Name of Supervisor: _____ Extension: _____

Health Insurance Company: _____ Personal Physician: _____

Incident:
Date: ___/___/_____ Day of Week: _____ Hour of Day: _____ ☐AM ☐PM

Hour shift began: _____ ☐AM ☐PM Time incident reported to supervisor: _____ ☐AM ☐PM

Date incident reported to supervisor: ___/___/_____ Date supervisor filled out report: ___/___/_____

Cause: _____ (i.e. Bending, Slip and Fall, Repetitive Motion) Body Part: _____ (i.e. Arm, Back, Wrist, Knee) Type: _____ (i.e. Laceration, Strain/Sprain, Fracture)

Will the individual miss work beyond the date of injury: ☐Yes ☐No

If "Yes", date individual left work: ___/___/_____ and date returned to work: ___/___/_____

Number of **hours** individual works **per day**: _____ Number of **days** individual works **per week**: _____

How did the accident occur? _____

_____
(Name the chemical which irritated skin; identify the object and weight being lifted, pulled, etc.)

Location of Incident or Exposure: _____
(Building, room, parking lot, off-campus address, etc.)

Witness(es) of incident: _____

Did individual receive medical care? ☐Y ☐N Where? _____

Attending Physician's Name: _____ Referred to: specialist's name: _____

Has the doctor provided a note returning the employee to full-duty? ☐Y ☐N

Supervisor's Corrective Action Plan

- Thoroughly investigate the probable causes of this incident.
- List the action that will be taken to prevent a reoccurrence of this incident. These actions may include, but are not limited to: training or re-training, purchasing safety equipment, replacing machinery lacking current safety technology, policy changes, process improvements, increased supervision, or requesting an evaluation from Risk Management & Safety.
- Assign a responsible person to implement each corrective action , and establish a completion date.

Action	Owner	Assigned Date	Completed Date
1. _____	_____	___/___/_____	___/___/_____
2. _____	_____	___/___/_____	___/___/_____
3. _____	_____	___/___/_____	___/___/_____

_____
Supervisor's Signature

WORKERS' COMPENSATION INFORMATION

Brigham Young University provides Workers' Compensation benefits to **all** personnel, which cover medical services, lost work time compensation, permanent disability and death benefits for work-related injuries and illness. The number for the Workers' Compensation Office is 378-6881.

For your protection, Utah law requires the following to appear on this form: "Any person who knowingly presents a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report of billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

EMPLOYEES WHO EXPERIENCE A WORK RELATED INJURY OR ILLNESS ARE RESPONSIBLE TO:

1. DETERMINE THE EXTENT OF MEDICAL CARE NEEDED.
2. IMMEDIATELY REPORT THE INJURY/ILLNESS TO YOUR IMMEDIATE, FULL-TIME SUPERVISOR.
3. IF POSSIBLE, ASSIST THE SUPERVISOR IN THE COMPLETION OF THE "SUPERVISOR'S INCIDENT INVESTIGATION REPORT."
4. OBTAIN INITIAL MEDICAL TREATMENT AT AN APPROVED FACILITY.
   a. Employees who experience minor injuries should report to the BYU Health Center Urgent Care.
   b. For serious emergencies or when the Health Center is closed, report to the Utah Valley Regional Medical Center emergency room.
   c. A copy of the "Supervisor's Incident Investigation Report" should be given to the treating facility.
   d. Employees who disregard this instruction and go directly to their own doctor may lose their claim to compensation benefits.
   e. Employees who sustain a dental injury that requires medical care should consult their dentist or contact Risk Management for a referral.
   f. Employees should inform the treating doctor/facility that the injury/illness is to be initially handled as an industrial claim.
5. FOLLOW-UP TREATMENT
   a. Any treatment beyond the initial visit requires pre-authorization from the Workers Compensation Office.
   b. Ensure the treating doctor submits written approval information for all lost time from work to Workers' Compensation Office.
   c. A written return-to-work slip, including work restrictions, should be submitted to your supervisor and Workers' Compensation, upon return to work.
   d. Doctor's recommendations regarding medical care, lost work time, and medication must be followed.
   e. Report to your full-time supervisor on a frequent basis regarding your health and work status.
6. PRESCRIPTIONS
   a. Prescriptions should be purchased from the BYU Health Center pharmacy, Smith's Pharmacies, or Albertson's Pharmacies.
   b. Use of prescriptions drugs which may impair their ability to perform their job duties, must be reported to their supervisor.
   c. **Full-time personnel should NOT use their DMBA prescription card when obtaining prescriptions for work related injuries/illnesses.**
7. ACCEPTANCE/DENIAL OF CLAIM
   a. The Workers' Compensation personnel may contact you to obtain missing accident report information and/or request additional information to determine if your claim is eligible for benefits.
   b. If your claim meets the guidelines for a work-related accident illness as set by state law, a copy of the "Employer's First Report of Injury" form will be sent to you.
   c. If the claim is denied, a letter will be sent to your home stating the reason(s) for denial.
8. BILLING
   a. Since BYU is self-insured, the medical information and billing should be submitted to the **BYU Risk Management and Safety Department, TOMH 124, PO Box 20100, Provo, UT 84602-0100.**
   b. Call 378-6881for billing questions.
9. MEDICAL RELEASE:

MEDICAL INFORMATION AUTHORIZATION

I AUTHORIZE THE BYU RISK MANAGEMENT & SAFETY DEPT. TO OBTAIN OR RELEASE INFORMATION RELATING TO THIS CLAIM.
I UNDERSTAND, AGREE AND CONSENT THAT THIS AUTHORIZATION SHALL REMAIN IN EFFECT INDEFINITELY.
A photocopy of this authorization shall be accepted as granting the same authority as the signed original.

Individual's Signature	Date	Witness of Signature

SUPERVISOR'S RESPONSIBILITIES:

1. ENSURE EMPLOYEES RECEIVE APPROPRIATE MEDICAL TREATMENT.
2. INVESTIGATE THE CAUSE OF EVERY INDUSTRIAL ACCIDENT, WHETHER OR NOT IT RESULTS IN AN INJURY AND DETERMINE HOW IT COULD HAVE BEEN AVOIDED.
3. COMPLETE THE "SUPERVISOR'S INCIDENT INVESTIGATION REPORT." SUBMIT FORM TO RISK MANAGEMENT WITHIN 24 HOURS OF INCIDENT.
4. IMMMEDIATELY REPORT ANY SERIOUS ACCIDENT OR INJURY TO RISK MANAGEMENT & SAFETY AT 378-4468.
5. COORDINATE WITH THE WORKERS' COMPENSATION OFFICE ON ANY WORK RESTRICTIONS.