

EMPLOYEE OCCUPATIONAL ACCIDENT REPORT



THE UNIVERSITY OF
ALABAMA IN HUNTSVILLE

Today's Date: _____ Case #: _____

1. CONTACT INFORMATION

Full Name: _____

UAH Email: _____

Phone: _____

A#: _____

Job Title: _____

Department: _____

2. ACCIDENT INFORMATION (be as specific as possible)

Date of Accident: _____

Time: _____

AM / PM

☐ On Campus

☐ Off Campus

Location (room, corridor, or outdoor reference point): _____

Describe what happened, how it happened, factors leading to the event, substances or objects involved: _____

Date Supervisor was Notified: _____

Date ORMC was notified: _____

3. INJURY DETAILS

Please describe the injury, include what part of your body is injured, and when the injury became apparent. _____

Was professional medical attention received for this injury? If yes, where?: _____

EMPLOYEE SIGNATURE *Please choose one of the options below, then sign and date.*

Information provided in this report is complete and accurate. I have reviewed the University's Employee Occupational Injury Policy and:

☐ I want to file an OJI claim. I understand this requires submission of an Employee Occupational Injury Claim & Medical Records Release form (Page 2) to the ORMC as soon as possible.

☐ I am not making an OJI claim. This is for reporting purposes only.

EMPLOYEE SIGNATURE

DATE

SUPERVISOR SIGNATURE *Please choose one of the options below, then sign and date.*

I have reviewed the accident report submitted by the employee under my charge and:

☐ to the extent of my knowledge, the information provided in this report is complete and accurate.

☐ I would like to submit comments regarding this claim. Comments may be attached to this report or emailed to riskmanagement@uah.edu.

SUPERVISOR SIGNATURE

DATE

EMPLOYEE OCCUPATIONAL INJURY CLAIM



THE UNIVERSITY OF
ALABAMA IN HUNTSVILLE

Today's Date: _____ Case #: _____

1. CONTACT INFORMATION

Full Name: _____

Home Address: _____

State: _____

Zip: _____

Birth Date: _____

Sex: _____

☐ Male

☐ Female

SSN: _____

Job Title: _____

Department: _____

2. WORK ABSENCE

Did your injury cause you to miss work on:

a. The day of the injury?

☐ Yes

☐ No

b. The day after the injury?

☐ Yes

☐ No

If you need to miss scheduled work hours in the future due to treatment of the injury, how do you wish to charge the time absent from work (select one or more below):

☐ Sick Leave

☐ Annual Leave

☐ Lost Wage Benefits*

*The maximum period for which lost wage benefits will be available is 180 consecutive calendar days from the date of the OJI

MEDICAL RECORDS RELEASE

1. I hereby authorize medical providers to disclose/discuss all medical record information pertaining to my on-the-job injury to/with my employer, the University of Alabama in Huntsville. The purpose of the disclosure is to allow representatives of my employer to review my request for benefits, or process medical claims or eligible reimbursements under the University's On-The-Job Injury Program. The type of information to be used or disclosed is as follows: All medical notes and/or reports in my file relating to this particular injury, as well as all notes and/or reports documenting a pre-existing injury that is the same in nature. (Including, but not limited to, medical history, medications, office visit notes, pathology reports, diagnostic studies, progress notes, physician's orders, laboratory results, imaging results, and discharge summaries.)
2. I understand that the information in my health record may include historical information relating to physical, behavioral, or mental health services, and treatment for alcohol and/or drug abuse.
3. I understand that this authorization is voluntary. However, if I refuse to sign this Medical Records Release the University cannot process my claim, and no lost wage and/or medical expense benefits will be provided.
4. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient, and the information may not be protected by federal privacy regulations.
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
6. Unless otherwise revoked, this authorization will remain valid until the expiration of all events related to the processing of claims relating to OJI benefits, not limited to participation in litigation or administrative hearings.

Employee/Claimant Signature

DATE

Signature of an individual who witnessed the claimant sign
(cannot be a supervisor)