Accidental Exposure/Incident Instructions for Resident - Flow Chart

Identify the site at which the accidental exposure/incident occurred and then follow the remainder of the instructions for that site:

**Site 1**
LOCATION: ANY WSU OR DMC BUILDING
1) Report to UHC 4K Occupational Health during business hours or ER after business hours
2) Inform Occupational Health that you are a WSU employee & were injured on job

PLEASE INFORM OCCUPATIONAL HEALTH to invoice WSU Office of Risk Management (ORM)
5700 Cass Ave., Suite 4622, Detroit, MI 48202

**Site 2**
LOCATION: HOSPITAL
1) Report to that Hospital's Employee Health during business hours or ER after business hours
2) Inform Employee Health that you are a WSU employee & were injured on job

PLEASE INFORM HOSPITAL Employee Health or ER to invoice WSU Office of Risk Management (ORM)
5700 Cass Ave., Suite 4622, Detroit, MI 48202

**Site 3**
LOCATION: DEARBORN SURGICAL CENTER
1) Report to OHMC Employee Health (basement MOB) for blood draw
2) Resident to provide incident report (from OakNet/Depts/Employee Health) with patient's info to OHMC Employee Health to follow up

PLEASE INFORM OHMC Employee Health to invoice WSU Office of Risk Management (ORM)
5700 Cass Ave., Suite 4622, Detroit, MI 48202

**Site 4**
LOCATION: PRIVATE PHYSICIAN OFFICE
1) Report to closest ER
2) Inform ER that you are a WSU employee & were injured on job

PLEASE INFORM HOSPITAL ER to invoice WSU Office of Risk Management (ORM)
5700 Cass Ave., Suite 4622, Detroit, MI 48202
REPORT OF INJURY FORM:
1. Download “Report of Injury” and “Supervisor Injury Investigation” forms from www.risk.wayne.edu or see last two pages
2. Have Program Director sign both forms as “supervisor”
3. Residency Program should return completed forms to:
   WSU Office of Risk Management (ORM)
   5700 Cass Ave., Suite 4622,
   Detroit, MI 48202
4. Delay in submitting form may generate delinquent payment
### Report of Injury

**NAME (Last, First, Middle):**

**SOCIAL SECURITY NO:**

**RESIDENTIAL ADDRESS (Street Address, City, State, Zip):**

**TELEPHONE NO(S.):**

<table>
<thead>
<tr>
<th>DATE OF INJURY:</th>
<th>TIME OF INJURY:</th>
<th>WORK START TIME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.M.</td>
<td>P.M.</td>
<td>A.M.</td>
</tr>
</tbody>
</table>

**Accident Reported to (name & title):**

**Witnesses:**
1. Full Name  Address  (Street, City, State, Zip)  Telephone No.
2. 

**Treating Physician:**

**Hospital (if hospitalized):**

**DESCRIPTION OF ALLEGED INJURY—WHAT ITEM CAUSED THE INJURY, BODY PART, AND EVENTS LEADING UP TO AND INCLUDING THE INJURY (PLEASE ATTACH A SECOND PAGE IF NECESSARY):**

**EXACT LOCATION AND/OR BLDG (including floor, room, etc.):**

**Birthdate (mm/dd/yy):**

**Sex:**
- □ Female
- □ Male

**Tax Filing Status (circle one):**
- □ Single
- □ Married, Filing Jointly
- □ If married, spouse is supported

**No. of Dependent (under age 16):**

**Other family members supported at least 50% by injured (specify on line below):**

**Lost Day(s) Due to Injury:**
- □ Yes  □ No

**Date of Last Day Worked:**

**Date returned to work/estimated length of disability:**

**Your Classification:**

**Your Department:**

**# of Hours Worked Per Week:**

**DATE OF HIRE:**

**Do you have a SECOND EMPLOYER?**
- □ Yes  □ No

**Company Name and Complete Address:**

**Public Safety Contacted:**
- □ Yes  □ No

**Case #**

**I Am Currently Enrolled As A Medicare (Not Medicaid) Beneficiary:**
- □ No  □ Yes, HCN#

**Your WSU Supervisor’s Complete Name, Phone Number and E-mail Address:**

**Your Complete Campus Address & Campus Phone:**

**Employee’/Student Signature/Date:**

**Supervisor’s Signature/Date:**

### INSTRUCTIONS:

ALL INFORMATION MUST BE COMPLETED AND BOTH SIGNATURES OBTAINED FOR EMPLOYEE INJURIES SUBMIT WITHIN 24 HOURS TO WAYNE STATE UNIVERSITY OFFICE OF RISK MANAGEMENT 5700 Cass Ave., Suite 4622, Detroit, MI 48202
SUPERVISOR’S INVESTIGATION REPORT
(print clearly or type)

Name of Injured Employee/Banner ID    Date

Job Title and Department

Date and Time of Injury     Type of Injury

When did you first learn of this injury? (Date & Time) ________________________________

What was the employee doing when injured? _____________________________________________

Where did the accident happen (incl floor/ rm no.)? ______________________________________

Was the injury caused by failure of injured to use safety equipment or observe regulations? ______
Describe what happened: _______________________________________________________________

What corrective steps will be done (or could be done) to prevent recurrence? ________________

Was the employee working at designated job? Yes o    No o
Is there any light duty available for the injured worker? Yes o    No o
Was WSU Police Department Contacted? Yes o    No o (case # __________)

Other Comments (optional):

Supervisor’s Signature ___________________________________________ Date _________________

Reviewed by Workers’ Compensation Coordinator __________________________ Date ______________

Return completed form within 48 hours of the injury to: Kristin Coles, Office of Risk Management, Suite 4622 AAB.
The “Supervisor’s Investigation Report” Form

The purpose of this form is to 1) gather information required in order to process the employee’s Workers’ Compensation claim; 2) determine what actions are needed to eliminate or control the hazards that have caused the accident. The information gathered will guide our staff in developing safety consciousness and knowledge of safe conditions and safe work methods.

If you are not aware of the circumstances surrounding the injury, please consult with the employee in order to complete the investigation report accurately. The statements made in this report are very important and should not contain phrases such as “Employee should be more careful.” As the supervisor, please make the appropriate corrective recommendations for each accident such as “notified the appropriate employee to place caution signs in the area when floors are wet.”

After you complete the investigation report, return it to Kristin Coles, Office of Risk Management, within 48 hours of the employee’s work related injury.

If you have any questions or concerns, call Kristin Coles, the workers’ compensation coordinator at 313-577-3112.