

Employee Accident/Incident Report
SOWELA Technical Community College
Human Resource Office

P. O. Box 16950, Lake Charles, LA 70616-6950 Computer Center, Room 5100, 337/491-2642

Each employee accident/incident must be reported on Form No. 228 in order for SOWELA to establish responsibility for insurance coverage with the Division of Administration. It is the responsibility of the supervisor to complete STCC1 Form No. 228, ORM Loss Prevention Form and the Medical Authorization Form in the following manner:

- A. As soon as the supervisor is notified of an accident/incident the Accident/Incident Report, STCC1 Form No. 228 and the ORM Loss Prevention Form should be completed and signed by the employee and their supervisor. The Medical Authorization Form should also be completed by the employee. Forms are also available in the Human Resources Office, Computer Center, Room 5100.
- B. If the employee goes to a physician, the employee should obtain the Authorization for Initial/ Emergency Medical Treatment Form from the Human Resources Office before going to the physician, hospital, etc. Once the employee has returned from the physician, the Original Employee Accident/ Incident Report form, the Medical Authorization, discharge instructions, etc. are turned into the Human Resources Office.
- C. If the employee does not see a physician, the Employee Accident/ Incident Report and the ORM Loss Prevention form are turned into the Human Resource Office as soon as possible.
- D. All charges for physicians, hospitals, prescriptions, etc. must be carried in the employee's name. Claims for reimbursement or payment of any charges may be forwarded to the Human Resource Office for transmittal to the Division of Administration, Office of Risk Management.

Dates/General Information

Date of Report _____ Date and Time of Accident/Incident _____

Name of Person Accident Reported to _____ Time Reported _____

Normal Starting Time Day of Accident _____ If employee back to work give date

Date Employer Knew of Injury _____ Date lost time began

Employee Information

Employee Name _____

Male/Female _____

Address _____ Employee Home Phone # (____) _____

Employee ID Number _____ Budget Unit Name/ Number

Supervisor's Name (please print) _____ Work Phone# (____) _____

Parish of Residence _____ Race _____ Marital Status _____

Number of Children under 18 _____ Date of Hire _____ No. Yrs Service _____

Present Age _____ Date of Birth _____

Department or Section Regularly Employed _____

Place of Injury -(Employer's Premises) Yes or No

Occurrence

Exact Location Where Accident Occurred _____

What was employee doing when injured? (Be specific - if using tools or equipment or handling material-name them and tell what you were doing with them)

How did Injury Occur? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substance involved and tell how they were involved. Give full details on all factors which led or contributed to injury or disease.)

Name and work phone numbers of all witnesses _____

Did Injury or Disease Occur Because of: Mechanical defect: Yes No - Unsafe Act: Yes No

If yes, explain _____

Nature and Location on Injury or Disease (Describe Fully, include Parts of Body Affected)

Did employee see physician, hospital, etc.? Yes or No

Attending Physician and Address (If Hospital involved, please indicate) _____

Date

Employee's Signature

Date

Supervisor's Signature

