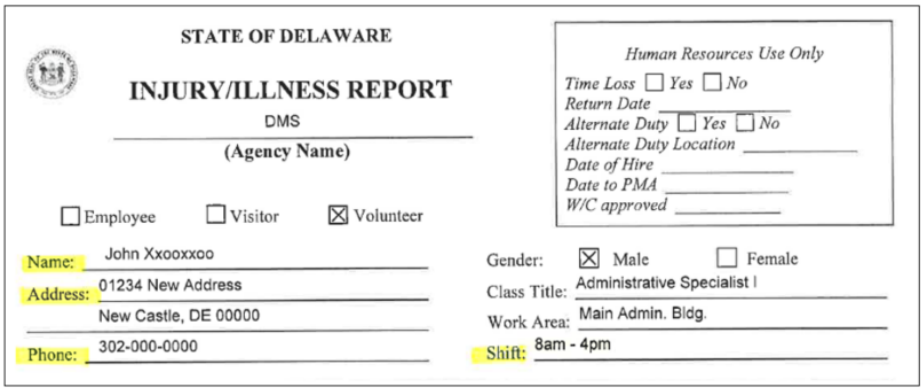
DHSS Job Aid: Submitting Workers' Compensation Claim

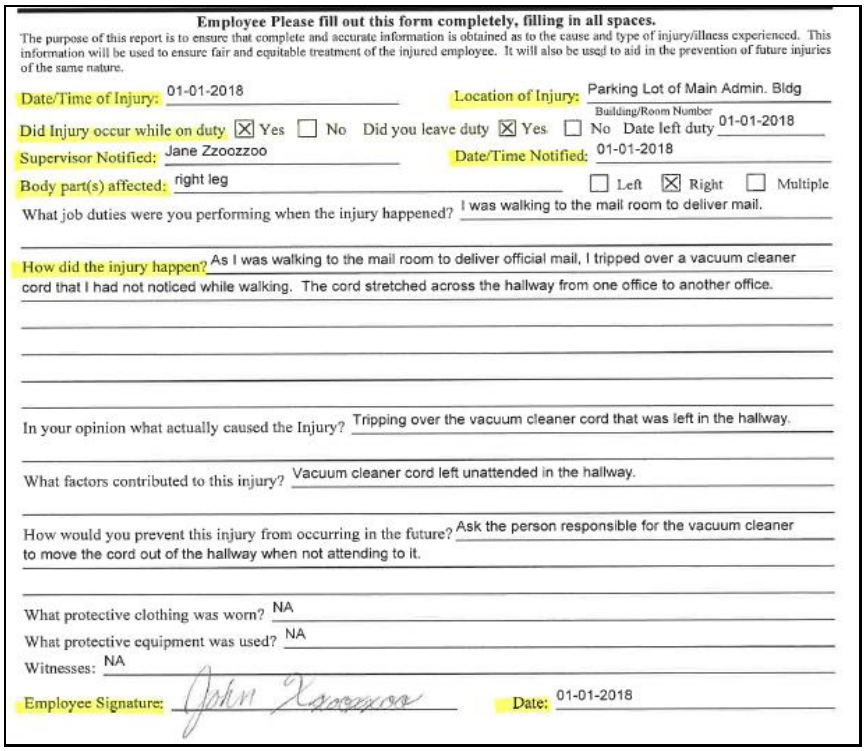
When an employee sustains a work-related injury or illness, the employee is required to submit a First Report of Injury/Illness Report.

1.	The Injury/Illness Report consists of four parts: 1. Employee's Personal Information (filled out by the employee) 2. Nature of Injury (filled out by the employee) 3. Accident Investigation Report (filled out by the supervisor) 4. Safety Champion (if applicable to the employee's facility) Click on the link to access the Injury/Illness Report – Workers' Compensation Claim form and follow the steps below. https://dhr.delaware.gov/inscov/doc/illness-injury-wc.pdf
2.	The first section of the Injury/Illness Report will be filled out by the employee. This section should be filled out in its entirety, with the exception of the "Human Resources Use Only" section. Enter the information in the following fields. Agency Name: Division (example: DMS) Name: the **full name** of the employee as listed in PHRST. Address: **personal mailing address** Phone: **personal phone number** Gender: select male or female Class Title: the name of employee's work title Work Area: name of the building the employee works in Shift: **regular work schedule** (start and end time)  STATE OF DELAWARE INJURY/ILLNESS REPORT DMS (Agency Name) ☐ Employee ☐ Visitor ☒ Volunteer Name: John Xxooxxoo Address: 01234 New Address New Castle, DE 00000 Phone: 302-000-0000 Human Resources Use Only Time Loss ☐ Yes ☐ No Return Date Alternate Duty ☐ Yes ☐ No Alternate Duty Location Date of Hire Date to PMA W/C approved Gender: ☒ Male ☐ Female Class Title: Administrative Specialist I Work Area: Main Admin. Bldg. Shift: 8am - 4pm ***Items highlighted in yellow are required***

3. The second section requests information about the nature of the injury. Fill out all areas of this section before moving on to the next section.

Enter the information in the following fields.

Date/Time of Injury: **record the date and time of the injury**
Location of Injury: **building, room #, or outside area where the injury occurred**
Did injury occur while on duty: **answer yes or no**
Did employee leave duty: answer yes or no, if yes, enter the date that the employee left duty
Supervisor Notified: **name of supervisor and date/time that they were notified**
Body part(s) affected: **list all parts of the body that are injured and which side of the body the injury occured**
For the next few questions on the report, answer with as many details as possible.
Witnesses: if witnesses, answer yes and attach their statement. If no witnesses, answer "NA."
Employee Signature and Date: **employee must sign and date the Injury/Illness Report.**



Employee Please fill out this form completely, filling in all spaces.

The purpose of this report is to ensure that complete and accurate information is obtained as to the cause and type of injury/illness experienced. This information will be used to ensure fair and equitable treatment of the injured employee. It will also be used to aid in the prevention of future injuries of the same nature.

Date/Time of Injury: 01-01-2018 Location of Injury: Parking Lot of Main Admin. Bldg (Building/Room Number)

Did Injury occur while on duty ☒ Yes ☐ No Did you leave duty ☒ Yes ☐ No Date left duty 01-01-2018

Supervisor Notified: Jane Zzoozzoo Date/Time Notified: 01-01-2018

Body part(s) affected: right leg ☐ Left ☒ Right ☐ Multiple

What job duties were you performing when the injury happened? I was walking to the mail room to deliver mail.

How did the injury happen? As I was walking to the mail room to deliver official mail, I tripped over a vacuum cleaner cord that I had not noticed while walking. The cord stretched across the hallway from one office to another office.

In your opinion what actually caused the Injury? Tripping over the vacuum cleaner cord that was left in the hallway.

What factors contributed to this injury? Vacuum cleaner cord left unattended in the hallway.

How would you prevent this injury from occurring in the future? Ask the person responsible for the vacuum cleaner to move the cord out of the hallway when not attending to it.

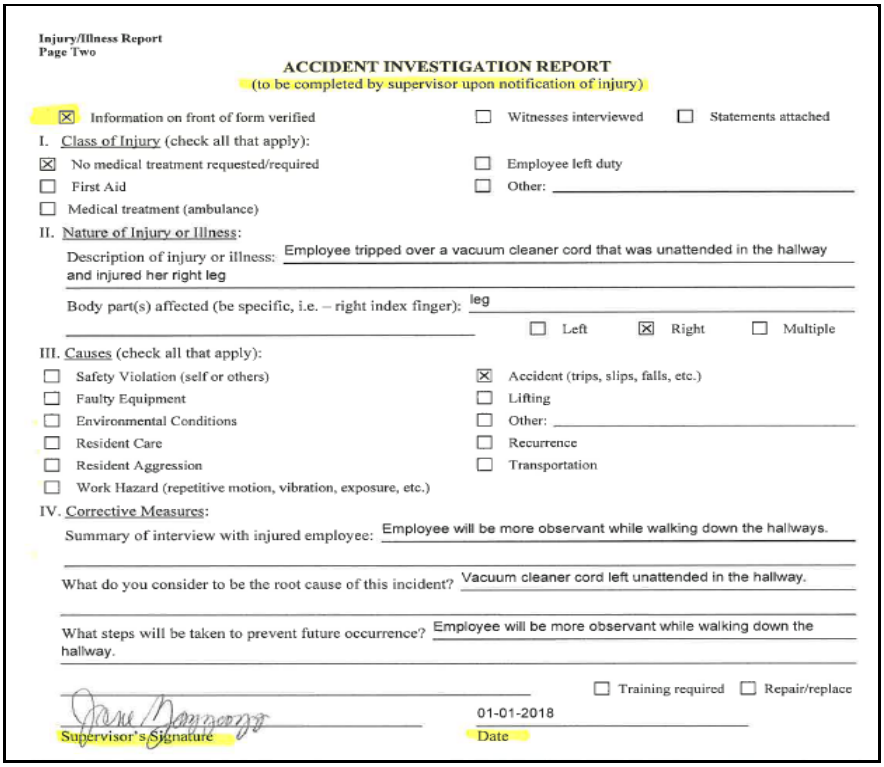
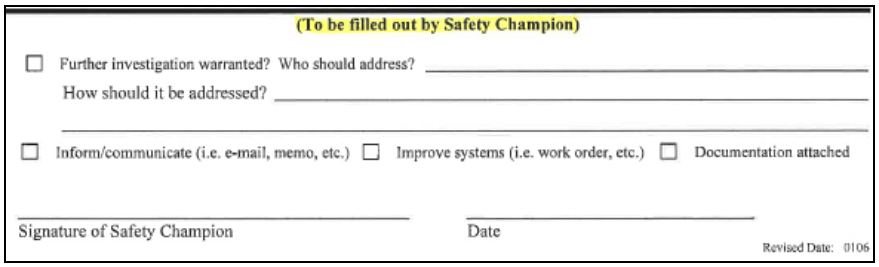
What protective clothing was worn? NA

What protective equipment was used? NA

Witnesses: NA

Employee Signature: John Zzoozzoo Date: 01-01-2018

Items highlighted in yellow are required

4.	The third section is the Accident Investigation Report, which is filled out by the supervisor. Fill out all areas of this section, along with the required **signature and date**. 
5.	The forth section is designated to the Safety Champion. This section only needs to be filled out if the facility requires a Safety Champion's signature on the Injury/Illness Report. 
6.	Once the Injury/Illness Report is compete, the report should be emailed to the ACT Case Management team's mailbox, at **DHSS_ACT@delaware.gov**.

Injury/Illness Report
Page Two

ACCIDENT INVESTIGATION REPORT
(to be completed by supervisor upon notification of injury)

☒ Information on front of form verified ☐ Witnesses interviewed ☐ Statements attached

I. Class of Injury (check all that apply):

☒ No medical treatment requested/required ☐ Employee left duty
☐ First Aid ☐ Other: _____
☐ Medical treatment (ambulance)

II. Nature of Injury or Illness:

Description of injury or illness: Employee tripped over a vacuum cleaner cord that was unattended in the hallway and injured her right leg

Body part(s) affected (be specific, i.e. – right index finger): leg

☐ Left ☒ Right ☐ Multiple

III. Causes (check all that apply):

☐ Safety Violation (self or others) ☒ Accident (trips, slips, falls, etc.)
☐ Faulty Equipment ☐ Lifting
☐ Environmental Conditions ☐ Other: _____
☐ Resident Care ☐ Recurrence
☐ Resident Aggression ☐ Transportation
☐ Work Hazard (repetitive motion, vibration, exposure, etc.)

IV. Corrective Measures:

Summary of interview with injured employee: Employee will be more observant while walking down the hallways.

What do you consider to be the root cause of this incident? Vacuum cleaner cord left unattended in the hallway.

What steps will be taken to prevent future occurrence? Employee will be more observant while walking down the hallway.

☐ Training required ☐ Repair/replace

Supervisor's Signature 01-01-2018 Date

(To be filled out by Safety Champion)

☐ Further investigation warranted? Who should address? _____
How should it be addressed? _____

☐ Inform/communicate (i.e. e-mail, memo, etc.) ☐ Improve systems (i.e. work order, etc.) ☐ Documentation attached

Signature of Safety Champion Date

Revised Date: 0106