Employee: **Return this form to your supervisor or Human Resources within 24 hours of the injury or onset of illness.**

Supervisor: **Turn this form into Human Resources immediately.**

We are located in Memorial Hall, Room 19, or Campus Box 79

WORKERS' COMPENSATION REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:
Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION: (612) 330-1058

CALLER'S TITLE:

CALLER'S NAME: Augsburg University

REPORTING STATE: Minnesota

SUBSIDIARY NAME:

SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP): 2211 Riverside Avenue, Minneapolis, MN 55454

SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP): ☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME: Augsburg University

LOCATION CODE:

POLICY SYMBOL AND NUMBER: TC2JUB 230T5559

NATURE OF BUSINESS: Higher Education

DATE OF INJURY:

TIME OF INJURY:

ACCIDENT DESCRIPTION:

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:

EMPLOYEE'S NAME (FIRST, MI, LAST):

GENDER: ☐ MALE ☐ FEMALE

DATE OF BIRTH:

EMPLOYEE'S MAILING ADDRESS:

EMPLOYEE'S HOME PHONE NUMBER: (   )

EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING):

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE: ☐ FULL-TIME ☐ PART-TIME ☐ OTHER

INJURED WORKER TYPE:

REGULAR OCCUPATION:

OCCUPATION WHEN INJURED:

EMPLOYEE'S WORK SCHEDULE
REGULAR WORK HOURS   HOURS/DAY   DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION:
$ ___________ / HOUR OR $ ___________/ ANNUAL OR $ ___________ / WEEKLY   OVERTIME: $ ___________   ADDITIONAL BENEFITS: $ ___________.

DATE OF HIRE OR LENGTH OF EMPLOYMENT:

SUPERVISOR'S NAME:

SUPERVISOR'S PHONE NUMBER: (   )

BEST HOURS TO CONTACT:

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?

DID EMPLOYEE LOSE ANY TIME FROM WORK? ☐ YES ☐ NO

IS THE EMPLOYEE BACK AT WORK? ☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS: ☐ LIGHT ☐ MODIFIED ☐ REGULAR

DATE EMPLOYEE LAST WORKED:

WAS INJURY FATAL? IF YES, DATE OF DEATH ☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL):

CONTRIBUTING FACTORS:

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED:

CONTINUED ON REVERSE SIDE

IF OTHER PEOPLE WERE INVOLVED

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

DO YOU QUESTION THE VALIDITY OF THE CLAIM?

☐ YES ☐ NO

WITNESS INFORMATION

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY

☐ FIRST AID —	TREATMENT AND DATE OF 1ST TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED?
☐ PHYSICIAN —	

Minnesota-specific questions:

Employee's Regular Department: ______________________________________

Was employee an apprentice? **Yes No**

Was employee furnished meals or lodging in addition to wages? **Yes No** *If yes, amount* $_________

If employee has other regular employment, indicate weekly wage $______________

Unemployment ID Number 7931801-000

SIC Code Number 820

CUSTOMER SPECIFIC INFORMATION

HR: fax completed form to 1-877-784-5329
(updated 2.11.16)

ADDITIONAL COMMENTS & INFORMATION