Print Form

COLUMBIA UNIVERSITY HUMAN RESOURCES

Departmental Accident Report Form

for Workers' Compensation Benefits

Employee Information

To be completed by the employee

Last Name: _____ First Name: _____

Employee ID: _____ Date of Birth: __/__/____ Home Phone: (___) ___-____

Address: _____ Apt. #: _____

City, State, ZIP: _____

Employment Date: __/__/____ CU Department: _____ Occupation: _____

Work Phone: (___) ___-____ ☐ Part Time ☐ Full Time

Wages per week: $_____ Days per week worked: _____ Regular Days Off: _____

Accident Information

To be completed by the employee—all questions required

Date of injury/illness: __/__/____ Time of injury/illness: _____ Time you started work: _____

Location (building, room) where injury/illness occurred: _____

What were you doing when injury/illness occurred?: _____

How did the injury/illness occur?: _____

Was the injury caused by a sharp object (needle, scalpel, razor, etc.)? If so, you must specify the device type and brand: _____

Describe the object or substance (chemical, blood, etc.) which directly injured you: _____

Describe the injury/illness—indicate type of injury, specify left or right, and so on, for example, "upper right leg": _____

To whom did you report the accident?: _____ Date Reported: __/__/____ Time reported: _____

Witness's Name: _____ Witness's address: _____

Supervisor's Statement

To be completed by the supervisor

Was employee paid for the full day? ☐ Yes ☐ No Is employee losing time? ☐ Yes ☐ No

Employee's first day away from work: __/__/____ Has employee returned to work? ☐ Yes ☐ No

Is employee a union member? ☐ Yes ☐ No Expected date of return to work: __/__/____

Will the employee be paid for lost time? ☐ Yes ☐ No Did the injured employee receive medical attention? ☐ Yes ☐ No

Name and address of doctor or hospital where first treated: _____

Who investigated the accident? Name: _____ Title: _____

Work Phone: (___) ___-____ Fax: (___) ___-____

Supervisor's discussion with employee on HOW TO PREVENT THIS TYPE OF INJURY/ILLNESS: _____

Signatures

I CERTIFY THAT THE ACCIDENT INFORMATION PROVIDED ABOVE IS TRUE.

EMPLOYEE Signature: _____ Date *(mm/dd/yyyy)*: _____

Supervisor's comments: _____

SUPERVISOR Signature: _____ Date *(mm/dd/yyyy)*: _____

Self Insured Workers' Compensation Program

Employee's Authorization for Release of Medical Information

To Whom It May Concern:

I hereby request and authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of me, to disclose, whenever requested to do so, by ***GAB Robins as the third party administrator for the self insured employer, Columbia University***, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Date of Birth: ___/___/_____

Last Name: _____ First Name: _____

Address: _____ Apt. #: _____

City, State, ZIP: _____

Home Phone: (___) ___ – _____ Work Phone: (___) ___ – _____

Signature:_____ Date *(mm/dd/yyyy):*_____

Please send all medical records to:

GAB Robins
123 William Street, 15th Floor
New York, NY 10038
Phone: 212-815-8900
Fax: 212-732-5509