

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

Emp. Code _____ Fund _____ Dept. _____

The filing of this report by an employer is required by law. It does not satisfy the employee's obligation to file a claim.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

| | | | | |
|------------------------|---|-------------------|------------------------------------|------------------|
| Employee's Name | The University of North Carolina at Greensboro | | | (336) 334-5009 |
| | Employer's Name | | | Telephone Number |
| Address | Human Resource Services, P.O. Box 26170 | Greensboro | NC | 27402 |
| | Employer's Address | | | City State Zip |
| City | State | Zip | Key Risk Management Services, Inc. | |
| () | () | | Insurance Carrier | |
| Home Telephone | Work Telephone | P.O. Box 49129 | Greensboro | NC 27419 |
| | | Carrier's Address | City | State Zip |
| | <input type="checkbox"/> M <input type="checkbox"/> F | (800) 366-1511 | (336) 605-7300 | |
| Social Security Number | Sex | Date of Birth | Carrier's Telephone Number | Fax Number |

| | |
|-----------------------------------|--|
| Employer | 1. Give nature of employer's business: Education and Research |
| | 2. Location of plant where injury occurred County _____ Department _____ State if employer's premises _____ |
| | 3. Date of injury _____ 4. Day of week _____ Hour of day _____ : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. 5. Was employee paid for entire day _____ 6. Date disability began _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. 7. Date you or the supervisor first knew of injury _____ 8. Name of supervisor _____ |
| Person Injured | 9. Occupation when injured _____ |
| | 10. (a) Time employed by you _____ (b) Wages per hour \$ _____ |
| | 11. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. of days worked per week _____ (d) Avg. weekly wages w/ overtime \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per |
| Cause And Nature Of Injury | 12. Describe fully how injury occurred and what employee was doing when injured (Statement made without prejudice and without vouching for correctness of information) |
| | 13. List all injuries and specify body part involved (e.g. right hand or left hand) _____ |
| | 14. Date & hour returned to work _____ at _____ : _____ .M. 15. If so, at what wages \$ _____ per |
| | 16. At what occupation _____ 17. Employee's salary continued in full? _____ |
| | 18. Was employee treated by a physician _____ |
| Fatal Cases | 19. Has injured employee died _____ 20. If so, give date of death (Submit Form 29) _____ |

Employer name: The University of North Carolina at Greensboro Date Completed _____

Signed by _____ Official Title Supervisor

THIS REPORT MUST BE TRANSMITTED TO THE INDUSTRIAL COMMISSION THROUGH THE UNIVERSITY'S INSURANCE CARRIER.

OSHA 301 Information:

| | | | | |
|-----------------------------|--|---|---|---|
| Case Number from Log: _____ | Date Hired: _____ | Time Employee began work on date of incident: _____ : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | If off-site medical treatment provided, answer entire next line. | |
| Name of facility: _____ | Address: Street/City/Zip/Telephone _____ | | ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No | Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

For IC use ONLY

Nature _____
Body _____
Cause _____
SIC _____
Coder _____

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This report must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para cerciorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [I.C. FILE NUMBER] (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.