ACCIDENT REPORTS/INSURANCE CLAIMS FOR STUDENTS

STUDENT RESPONSIBILITY:
1. The student must fill out a College accident report for each incident regardless of whether or not he/she is treated by a doctor or at a hospital.
2. A student who requires treatment by either a doctor or at the hospital must also fill out a claim form and have the medical facility and/or doctor fill out the appropriate section(s) and return to the KVCC Business Office.
3. All sections of the form must be completed including the section regarding the student's insurance coverage by any other hospital or medical insurance plans.
4. Forms are available from faculty members or from the KVCC Business Office.

STAFF/FACULTY MEMBER RESPONSIBILITY:

It is the responsibility of any staff member or faculty member who is witness to an accident or incident to make every effort to insure that an accident report is filled out and signed.

MEDICAL FACILITY/DOCTOR RESPONSIBILITY:

Fill out and sign the back portion of the claim form, attach itemized bill and mail both to KVCC Business Office.

KVCC BUSINESS OFFICE RESPONSIBILITY:
1. The Business Office will provide forms (accident report & claim forms) upon request from students.
2. It will be the responsibility of the Business Office to insure prompt transmittal of the claim form and pertinent bills to the College's insurance carrier.
3. Copies of the incident/accident reports will be sent to the Safety Officer.

SAFETY OFFICER RESPONSIBILITY:
1. The safety officer will review all reports with the safety committee members as part of the committee's regularly scheduled meetings.
2. The safety officer will follow up all reports with the student involved and report the status to the safety committee.
3. Written records will be maintained of all reports and of the on-going or final status of reported incident/accident.
REPORT OF STUDENT INJURY OR ILLNESS

STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SS#</th>
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</tbody>
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Address - Number and Street

City | State | Zip

Home Phone | Home e-mail address

Date of Birth | Age | Sex: ☐ Male ☐ Female

Campus: __________________________________________________________
Program: _______________________________________________________
Year in Program: 1st yr. _______ 2nd yr. _______ Other ______________

INJURY OR EXPOSURE INFORMATION

Date and time of injury/exposure _______________________________ a.m. ___ p.m. ____
Place of injury/exposure: Building __________ Grounds ________ Off-campus ________

Describe the events which resulted in the injury or illness (give full details on all factors that led or contributed to the injury or the onset of illness). Please explain how the injury/illness occurred (e.g. student cut foot on broken glass):

Name the object, substance or exposure which directly brought about the injury or illness (e.g. slippery floor, speeding truck):

Describe the injury or disease and indicate part of body affected (nature of injury/illness e.g. strain, break, cut and part of body)

Physician Name and Address: ❑ First Aid ❑ Hospital ❑ Emerg. Room ❑ Out-patient

Hospital Name and Address: ______________________________________________________

(see reverse side)
Degree of injury/illness: non-disabling _______ death _______ (date_____________)
_____permanent incapacity ______ temporary incapacity (date incapacity began: ________)
Has student returned to program? _____Yes _____ No If yes, give date: ________________

FOR ILLNESS RELATED TO COURSE OF STUDY

Date of Last exposure __________________________ Date of Clinical Diagnosis __________________________

******************************************************************************
Faculty Member in charge when/where accident or exposure occurred: ___________________
Witnesses: ___________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Report prepared by: Name ______________________________________________________
Title _______________________________________________________
Signed _______________________________________________________  
Date _______________________________________________________

Reviewed by Safety Committee:  
Report reviewed by: 
Names: ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Date: _______________________________________________________

Comments: ___________________________________________________________________
________________________

Copy to: ________ Risk Management Division  
Dept. of Admin.  
Station 85  
Augusta, ME 04333  

______ Center for Occupational Health and Safety  
c/o Central Maine Community College  
1250 Turner Street  
Auburn, ME 04210  

______ Campus Office: __________________________
REPORT OF VISITOR INJURY OR ILLNESS

VISITOR INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>SS#</th>
</tr>
</thead>
</table>

Address - Number and Street

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Home Phone

Home e-mail address

Date of Birth

Age

Sex: ☐ Male ☐ Female

Campus: ____________________________________________________

INJURY OR EXPOSURE INFORMATION

Date and time of injury/exposure ____________________________ a.m. ___ p.m. ___

Place of injury/exposure: Building ________ Grounds _________ Off-campus _________

Describe the events which resulted in the injury or illness (give full details on all factors that led or contributed to the injury or the onset of illness). Please explain how the injury/illness occurred (e.g. student cut foot on broken glass):

Name the object, substance or exposure which directly brought about the injury or illness (e.g. slippery floor, speeding truck):

Describe the injury or disease and indicate part of body affected (nature of injury/illness e.g. strain, break, cut and part of body)

Physician Name and Address:

□ First Aid
□ Hospital
□ Emerg. Room
□ Out-patient

Hospital Name and Address:

(see reverse side)
Degree of injury/illness: non-disabling _______ death _______ (date_______________)
_____permanent incapacity _______ temporary incapacity (date incapacity began: _________)

FOR ILLNESS

Date of Last exposure ___________________________ Date of Clinical Diagnosis ___________________________

**************************************************************************************************************
Witnesses:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Report prepared by: Name ___________________________________________________
Title ___________________________________________________
Signed ___________________________________________________
Date ___________________________________________________

Reviewed by Safety Committee:
Report reviewed by: Names: ________________________________________________
__________________________________________________________________
__________________________________________________________________
Date: ___________________________________________________
Comments: ___________________________________________________

Copy to: _____ Center for Occupational Health and Safety
           c/o Central Maine Community College
           1250 Turner Street
           Auburn, ME 04210

           _____ Risk Management Division
           Dept. of Admin.
           Station 85
           Augusta, ME 04333

           _____ Campus Office: ________________________________
EMPLOYEE ACCIDENT REPORT

Name of Injured: _______________________________  Nature of Injury: _______________________________

Date: _________________________________________  Time: _____________________ □ a.m. □ p.m.

Location: Building: _____________________________  Room #: _____________ Area: _______________

Address: _______________________________________________________ (If location other than campus)

Was First Aid Given? □ yes □ no  If yes, by whom? ________________________________

Describe First Aid Given: ________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What other steps were taken besides First Aid?

Name of Doctor: ______________________________  Name of Nurse: ___________________________

Ambulance: _________________________________  Hospital: ________________________________

Cause of Injury: __________________________________________________________________________

________________________________________________________________________________________

Who saw the accident?

Name: _____________________________________  Address: ________________________________

Name: _____________________________________  Address: ________________________________

Had injured received safety instructions related to activity involved? □ yes □ no

When? __________________________________________________________________________________

What do you think caused the accident? ______________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What would prevent a recurrence of a similar accident? ________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Signed: _________________________________  Date: ________________________________
POLICY 5.02 - ATTACHMENT D: Claim Reporting Form. Please see the Business Office for a copy.