MISSOURI WESTERN STATE UNIVERSITY
INJURY/INCIDENT REPORT FOR EMPLOYEES

I. TO BE COMPLETED BY EMPLOYEE:			
Name: (last, first, MI)			
Address/Telephone Number: (home)			
SSN:		Birth Date:	
Position:		Hire Date:	
Number of Days Worked Each Week:		Time Workday Began on Date of Injury:	
Date/Time of Accident:		Location (BLDG/AREA)	
How did the incident occur? (Describe fully in your own words)			
Cause of the Incident:			
Name(s) of Witness(es):			
Nature of Injury:	Part of Body:	Type of Injury:	
What medical treatment, if any, did you seek? Who authorized it?			
I CERTIFY THE ABOVE INFORMATION TO BE TRUE:			
Signature:		Date:	

II. TO BE COMPLETED BY THE SUPERVISOR:
I am aware of the injury/incident reported above and the condition causing the event. I have taken steps to correct any safety hazard. Additional remarks:

Supervisor Signature ____________________ Date ____________________

RETURN TO RISK MANAGER, A221. BRING OR SEND ALL BILLS TO RISK MANAGER (Tim Kissock).			
Received:	Date:	Verbally notified:	Date:

(RM:injreprt 5/00)

III. TO BE COMPLETED BY MWSU HEALTH CENTER PERSONNEL:

Part injured:		
Injury type:		
Medical treatment:		
Referred to:		
Issued authorization for medical aid?	Yes ( )	No ( )
Employee returned to work?	Yes ( )	No ( )
When did temporary disability begin?		End?
Remarks:		
Signature of R.N.:		
Date:		

Additional Comments:

Instructions

An Injury/Incident Report Form must be completed for **any** incident occurring while **at work** at MWSU.

The employee completes Section I within 24 hours after the accident. The employee gives the form to his/her supervisor to review and sign (Section II). If treatment at the campus Health Center was not necessary or not obtained, send the form directly to the Risk Manager.

Section III is only completed when the employee seeks treatment at the campus Health Center by the nurse. The form is then forwarded to the Risk Manager.

Contact the Risk Manager, ext. 4466, if you have any questions.

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

NOTICE AND ACKNOWLEDGMENT OF RIGHT TO WORKERS' COMPENSATION BENEFITS	INJURY NUMBER

USE FOR ACCIDENTS INVOLVING LESS THAN $500 IN TOTAL MEDICAL COSTS AND NO LOST TIME FROM THE EMPLOYMENT, UPON RECEIPT OF THE NOTICE REQUIRED BY SECTION 287.380, RESMo.

1. Name of Employee	Address (street, City, County)	State	Zip Code	Telephone Number
2.Name of Employer	Address (street, City, County)	State	Zip Code	Telephone Number
Missouri Western State University	4525 Downs Drive St. Joseph, Buchanan	Missouri	64507	816-271-4466
3. Name of Insurer	Address (Street, City, County)	State	Zip Code	Telephone Number
Central Accident Reporting Office	P.O. Box 809 Jefferson City,	Missouri	65102	573-751-2837
4.Date of Accident/Injury	Location of Accident/Injury (Street/City/County)	State	Zip Code	Employee's Social Security

I, ___________________________________, understand that on the _____ day of ______________, 20____, while engaged in employment at MISSOURI WESTERN STATE UNIVERSITY, I suffered an injury or illness for which compensation is payable under the Missouri Workers' Compensation Law, and as an injured employee I am entitled to workers' compensation benefits. These benefits include:

(1) MEDICAL CARE TO CURE THE INJURY. The employer/insurer must provide all reasonable and necessary medical care to cure the injury/illness. There is no deductible, and all costs are paid directly by the employer/insurer (i.e. doctor bills, medicines, hospital costs, lab test fees, x-rays, crutches, etc. plus mileage.) The employer/insurer, however, has the right to choose the doctor, medical facilities, etc., and is not required to pay for the cost of any treatment not authorized by them.

(2) CASH PAYMENT FOR LOST WAGES. If an employee is unable to work more than three regularly scheduled work days because of a work-related injury/illness, the employer/insurer must provide the employee with "temporary disability" payments until the doctor says the employee is able to return to work. (This benefit does not apply to employees who have not missed any time from work.)

(3) ADDITIONAL CASH PAYMENTS. Once medical treatment is completed and a determination has been made that the injury has resulted in permanent disability, the employer/insurer is responsible for "permanent disability" payments, with the amount of compensation going computed according to the disability schedule, as provided by law.

Also, I understand that if I do not act to secure the benefits in a timely manner I may forfeit my right to such benefits. An employee must file a claim for compensation with two (2) years of the date of the injury or the date of the last payment for medical treatment provided on account of the injury. (However, the two (2) year period is extended to three (3) years if the employer/insurer does not timely file the Report of Injury with the Division of Workers' Compensation.)

I solemnly swear of affirm under the penalty of perjury that I have read and understand the Notice and Acknowledgment of Right to Workers' Compensation Benefits; or, through an alternative format, I have been advised of and understand the Notice and Acknowledgment of Right to Workers' Compensation Benefits.

Employee Name:	**Date:**
Employee Signature:	

Certificate:

The undersigned employer representative without admitting liability or the compensability of the alleged injury, certifies that a true and accurate copy of this notice has been hand-delivered to the above-referenced employee on the _______ day of ___________________, 20___, and is being mailed to the Division of Workers' Compensation accompanied by or affixed to the Report of Injury.

Employer Representative