Pacific Cooperative Studies Unit
3190 Maile Way St. John #411
Honolulu, Hawaiʻi 96822

August 9, 2018

TO: RCUH /PCSU Employees

FROM: PCSU Direct Projects Human Resources

SUBJECT: RCUH Injury Report Form and Important Reminders
(IMPORTANT - NEW Workers' Comp Adjuster)

Enclosed are the following:

1. RCUH's "***Supervisor's Report of Industrial Injury"***, *revised 08/03/16* (3 pages). **The employee MUST report injuries IMMEDIATELY to their supervisor. The Principal Investigator MUST report injuries to the RCUH Human Resources Office within 24 hours of Injury/Illness/Accident (see RCUH policy 3.930).**

   Although RCUH's form says to send reports directly to RCUH HR, **please send the injury report to PCSU (within 24 hours of Injury/Illness/Accident) for Principal Investigator's signature and review.**

   Email injury reports to Howard "Kahale" Pali (pali@hawaii.edu) and cc. Michelle Miyata (mmiyata@hawaii.edu), or fax to 808-956-4710.

2. RCUH's Director of Human Resources, Nelson Sakamoto's, "***Guidelines If You Suffer a Work-Related Injury/Illness***" memo, ***revised 06/28/2017*** (4 pages). Please be sure the employee has a copy of this memo – it will provide the employee with guidelines and (**NEW) Workers' Compensation billing information** for the doctor/hospital.

IMPORTANT REMINDERS:

- **Any** loss of work time (includes taking a sick day) due to injury/illness **MUST** be certified by a Physician.
- The employee is required to provide PCSU and RCUH with a Physician's Certification of Disability (i.e. doctor's note).
- Please remember to provide as many details on the Injury Report as possible (including pictures of the site of injury).

Any questions regarding Workers' Compensation,
please contact Michelle Miyata (mmiyata@hawaii.edu), phone: 808-956-9512.

Research Corporation
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Human Resources Department

Supervisor's Report of Industrial Injury

CONFIDENTIAL

Upon completion of this report, please fax to (808) 956-9423 or email (rcuhhr@rcuh.com) to RCUH HR within 24 hours of Injury/Illness/Accident. Original form should be sent to Burns Hall, 4th Floor, 1601 East West Road, Honolulu, HI 96848

(Part A and Part B MUST be completed)

1. EMPLOYEE'S NAME *(Last, First, MI)*	**2. PROJECT NAME**	**3. CLASSIFICATION:** ☐ Regular ☐ Student ☐ Temporary ☐ Volunteer
4. EMPLOYEE'S RCUH ID#	**5. EMPLOYEE'S ADDRESS** *(No., Street, City, State, Zip Code)*	**6. MARITAL STATUS** ☐ Single ☐ Married

7. DATE OF INJURY (MM/DD/YY)	**8. JOB TITLE**	**9. TIME WORKSHIFT BEGAN** ___________**A.M./P.M.**	**10. TIME OF INJURY** _________**A.M./P.M**

11. ACCIDENT LOCATION & ADDRESS (Ex., Loading dock north end; 2432 N. St. Hilo, HI)	**12. DATE INJURY REPORTED TO SUPERVISOR** (MM/DD/YY)	**13. WITNESS(ES) NAME** *(Last, First)*

14. HOW DID THIS ACCIDENT OCCUR? *(Please fully describe the events that resulted in injury or occupational disease. Explain what happened.)*

15. DESCRIBE THE SURROUNDING/ENVIRONMENT WHERE THE INJURY/ILLNESS OCCURRED (e.g. steep, wet slippery slope, etc.)

16. WHAT WAS THE EMPLOYEE DOING WHEN INJURED OR BECAME ILL? *(Please be specific. Identify tools, equipment or material the employee was using.)*

17. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE? *(e.g. the machine employee struck against or struck him, the vapor or poison inhaled or swallowed, etc.)*

18. EMERGENCY CARE AND PATIENT STATUS

☐ First Aid Only (i.e., employee was not referred to hospital or doctor).
☐ Referred to hospital/doctor, current status unknown (provide medical note if treated)
☐ Treatment at hospital/doctor (provide medical note and include doctor contact information below)

Physician Name:	
Address/Hospital Name:	
Phone Number/Email:	

19. EMPLOYEE STATUS

Was employee paid in full for day of accident? ☐ Yes or ☐ No

Has employee returned to work? ☐ Yes or ☐ No If "Yes", enter date returned: _____/_____/_____ (MM/DD/YY)

Will employee lose time from work? ☐ Yes or ☐ No If "Yes", please explain:____________________________________

____

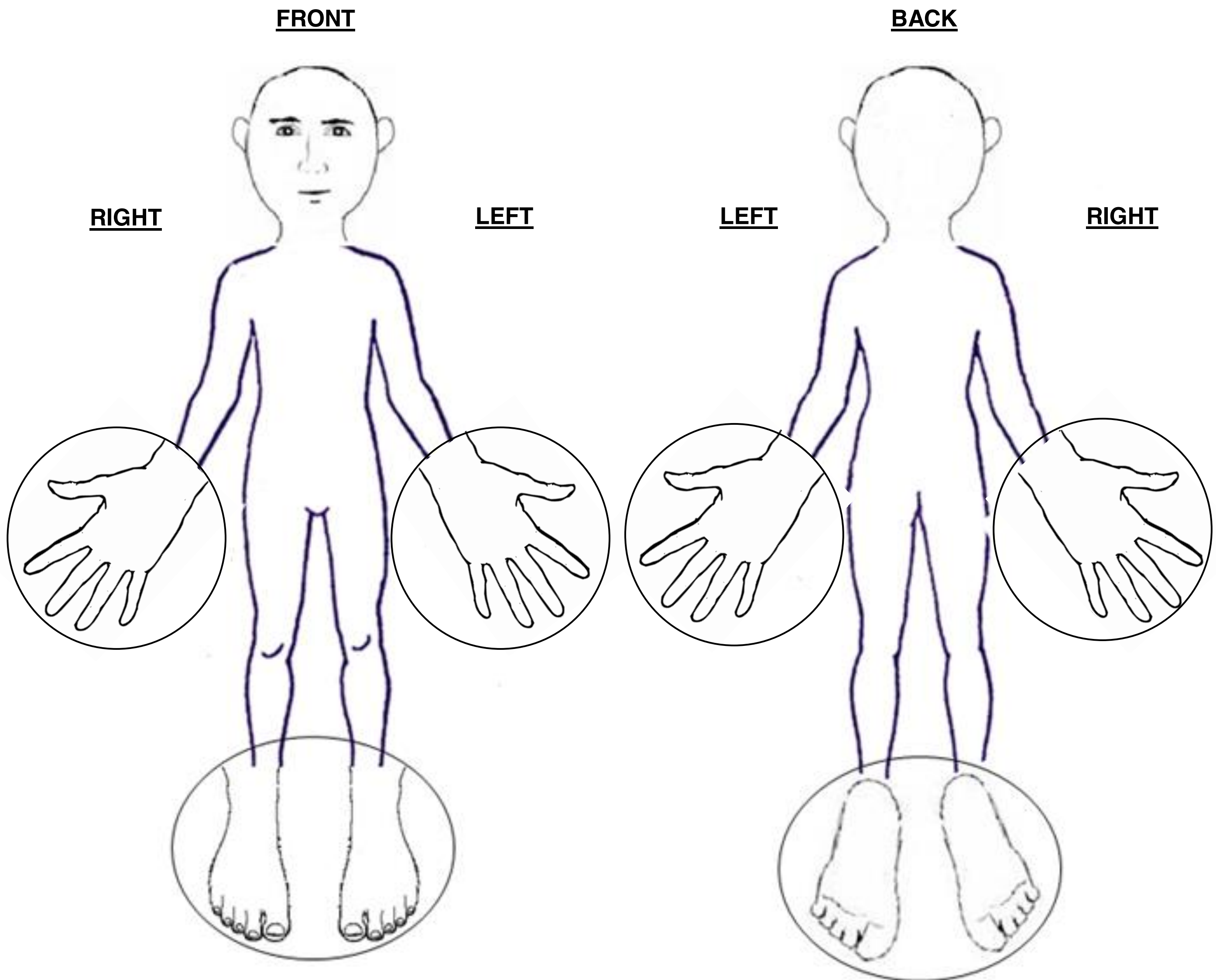
Any loss of work time due to this injury/illness must be certified by a Physician. Employee is required to provide the RCUH with a Physician's Certification of Disability.

20. IDENTIFY SPECIFIC BODY PART(S) INJURED. Describe the injury/illness and first aid administered by certified First Aider.: ____

____

____

***Mark ("X") the injured body part(s) on diagram below and have employee initial by the injured body part(s).



PART B: ACCIDENT INVESTIGATION (INCLUDE ATTACHMENTS):

1. What type of safety equipment and/or procedure was involved in this work process? Did the employee use the equipment or follow the procedure?

2. What kind of actions do you plan to implement to prevent this type of accident from recurring?

3. Have you instructed the employee on how to avoid the recurrence? How?

4. Was a Safety Rule violated? If so, has the employee been disciplined for violating the safety rule?

5. Please include photographs, diagrams or other descriptive documentation of the accident site to help better describe the location, environment, or other factors that caused/contributed to the accident. Number each photo and provide an explanation of what each photo represents. **DO NOT include photos of the injury or injured employee.**

STATEMENT OF CERTIFICATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION *(This authorization allows my physician, hospital, clinic, or other medical institution to release and allow RCUH and/or its insurance company access to information/documentation of treatments rendered to me for my injury/illness; includes results of accident or injury related testing, and as applicable prior medical history related to this injury/illness.) I understand any falsification of this information may result in disciplinary action including and up to termination of employment.*

Employee Name	Employee Signature	Date
Work Phone Number	Home/Cell Phone Number	E-mail Address

REVIEWED BY IMMEDIATE SUPERVISOR/SAFETY COORDINATOR AND PRINCIPAL INVESTIGATOR:

Supervisor Name	Supervisor Signature	Date
Phone Number	Fax Number	E-mail Address
Project Safety Coordinator Name	Project Safety Coordinator Signature	Date
Phone Number	Fax Number	E-mail Address
Principal Investigator Name	Principal Investigator Signature	Date
Phone Number	Fax Number	E-mail Address

REMINDERS:
1. Any loss of work time due to this injury/illness must be certified by a Physician. Employee is required to provide the RCUH with a Physician's Certification of Disability.
2. Complete and send this form in to the RCUH Director of Human Resources immediately via fax 808/956-9423, email rcuhhr@rcuh.com or mail original forms to John A. Burns Hall 4th Floor Makai Wing, 1601 East West Road, Honolulu, HI 96822.
3. Scan and encrypt email photo(s) of the equipment, location/work environment, object that may have caused the injury/illness. to rcuhhr@rcuh.com.
4. Refer to RCUH 3.580 Workers' Compensation and 3.930 Safety and Accident Prevention Program policies for more information.
5. Provide the Employee with the "Guidelines to Employee Memo" located on RCUH 3.580 Workers' Compensation policy.

Research Corporation
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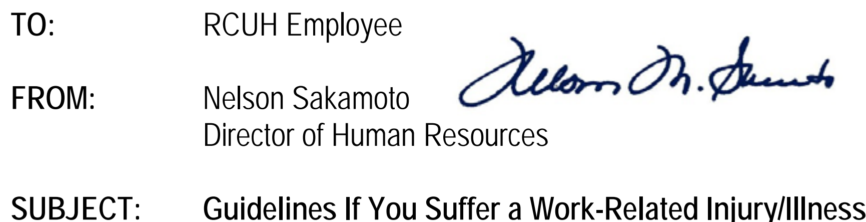
Human Resources Department

First issued: 06/27/2002
Revised: 09/25/2008, 08/26/2013, 08/03/2016, 11/02/2016, 06/28/17

MEMORANDUM

TO: RCUH Employee



FROM: Nelson Sakamoto
Director of Human Resources

SUBJECT: **Guidelines If You Suffer a Work-Related Injury/Illness**

If you have suffered a work-related injury or illness, you should read this memo and follow the guidelines provided below:

Applicable RCUH Policies:
1. RCUH Policy 3.580 RCUH Workers' Compensation Policy
2. RCUH Policy 3.930 RCUH Safety & Accident Prevention Policy.

Reporting Deadline of Any Work-Related Injury/Illness to Your Supervisor:
Any work-related injury/illness ***must be reported to your supervisor immediately after its occurrence.*** The RCUH Supervisor's Report of Industrial Injury & Accident Investigation Form (B-3) must be completed by your supervisor, reviewed/signed by you (injured employee) and your supervisor. The RCUH Supervisor's Report of Industrial Injury & Accident Investigation form may be obtained via the RCUH Home Page (www.rcuh.com).

Reporting Deadline for Your Supervisor's Report to the RCUH:
Both the Supervisor's Report of Industrial Injury Accident Investigation Form and the Employee/Claimant Consent Form must be sent to the RCUH Human Resources Department immediately (i.e., **within 24 hours of its occurrence**). An explanation may be needed, if there are any delays in reporting the claim.

RCUH Responsibilities in Reviewing & Reporting Your Claim:
The RCUH Human Resources Department will review the Supervisor's Report of Industrial Injury & Accident Investigation Report. The RCUH Human Resources Department may request clarification and may initially deny your claim until an investigation can be completed. The investigation is to ascertain whether the injury is job related. The RCUH will report claim to our third-party administrator, Sedgwick Claim Management Services as soon as we receive your claim.

Third Party Administrator Responsibilities in Claims Administration:
The RCUH has contracted an insurance company to provide the organization with a comprehensive workers' compensation insurance policy. All claims for workers' compensation made by an RCUH employee will be administered through a third-party administrator (i.e., Sedgwick Claims Management Services.). All issues relating to your claim will be handled by an assigned Claims Adjuster. You will receive a letter in the mail and/or a phone call from this Adjuster. The Adjuster will interact with you and your physician on all matters concerning your workers' compensation claim. You are to contact this Claims

Adjuster for any questions you have about your case. Cooperation is important.

Sedgwick Claims Management Services will complete a WC-1 Employer's Report of Industrial Injury form. This form will be sent to the State of Hawaii Department of Labor & Industrial Relations Disability Compensation Division within seven (7) working days from the date of injury. Therefore, it is very important that your accident is reported promptly to your supervisor so it can be delivered to Sedgwick Claims Management Services in a timely manner.

Workers' Compensation Benefits:

All benefits are specified in Chapter 386, of the Hawaii Revised Statutes (Hawaii Workers' Compensation Law, or related laws). In most cases, if your claim for benefits is accepted, these benefits will cover all medical expenses and lost work time due to disability from this work related injury.

Lost Time from Work:

All "lost time" due to the work-related injury must be certified by the employee's primary treating physician. The RCUH does not allow "back dated" (i.e., after the fact) medical certifications. Therefore, an employee must see his/her primary treating physician and be certified as disabled from work from the first day of his/her disability.

For wage loss replacement, there is a mandatory 3 calendar day waiting period. On the fourth calendar day of disability, the employee will commence receiving 66 2/3% of his/her Average Weekly Wage (AWW). Our respective insurance carriers are responsible for sending you your Temporary Total Disability (TTD) checks. This AWW will remain the same (i.e., based on the AWW value at the date of injury) throughout the duration of the claim. The employee is allowed to use sick leave during the first 3 calendar days of the waiting period or if the employee has no sick leave or vacation, he/she will be placed on a leave without pay status. All claims for workers' compensation benefits must adhere to the provisions of Chapter 386, H.R.S. (Hawaii Workers' Compensation Law).

Questions & Answers:

1. **What information do you need to provide to the doctor?**
   You will need to explain to the doctor's office that you are an employee of the RESEARCH CORPORATION OF THE UNIVERSITY OF HAWAII (RCUH). If they have any questions, have the doctor's office contact the RCUH Human Resources Department at (808) 956-3100. Please make sure you identify RCUH as your employer to avoid bills or reports from being sent to the wrong office.

   You should inform the physician "where you are injured", "when the injury occurred", and "what were you doing when the injury occurred".

2. **Where does the doctor's office send the bills and reports?**
   All billings and medical reports relating to your work injury should be sent to:

   Sedgwick Claims Management Services
   P.O Box 14541 Lexington
   KY 40512-4541
   (808) 523-3200 (main line)
   (859) 264-4062 (fax)

   Your doctor should call Sedgwick Claims Management Services if they have any questions relating to their claims processing.

3. **What happens if my claim is denied?**
   The RCUH will instruct the Claims Adjusters to review your claim for worker's compensation benefits to determine if it is "job related". Any lost time (related to the injury) during the "denial investigation" period, should be charged as "Sick Leave" (if available) or Leave Without Pay (if you are not eligible for sick leave). The Insurance Company and/or Claims Adjusters may request to review all relevant medical information from your physician and/or send you to an independent medical review. A determination will be made approximately thirty (30) days from the report of injury. You will be notified by the Claims Adjuster of this determination.

   The Claims Adjustor will inform you if your claim is determined to be "compensable" (i.e., you are eligible for workers' compensation benefits). Any sick leave payments will be adjusted for TTD benefits. Upon receipt of the TTD payment, the RCUH Human Resources Department will adjust your sick leave records (i.e., restore the sick leave applicable to the TTD payment/period).

4. **Who do I inform about any changes in my work status, schedule, etc.?**
   You need to inform both your Supervisor and the Claims Adjuster. All medical reports should be sent to the Claims Adjuster (i.e., Sedgwick Claims Management Services, Inc.). Any changes in your work schedule due to disabilities, treatments, etc. must be coordinated with your Supervisor and the Claims Adjuster. You and your doctor should try to schedule all appointments during your "off hours". Contact your Claims Adjuster if you and/or your physician cannot schedule the appointments, treatment, or therapy outside of your work schedule. Your Claims Adjuster and your Supervisor will need this information.

5. **Who needs to know about my condition?**
   (1) Your Supervisor/PI: You should provide your supervisor with information on how your injury will affect doing your job. Your condition may affect your ability to return to work, your work schedule, and/or your ability to perform your job.
   (2) Your WC Claims Adjuster: You must provide your adjuster with any/all medical reports from your doctor.

6. **What do I do if I disagree with any action taken by the Claims Adjuster?**
   You are to contact Norma Loo, Adjuster of Sedgwick Claims Management Services

7. **What do I do if I disagree with any action taken by my Supervisor relating to my claim?**
   You are to contact the RCUH Human Resources Department and ask to speak to the Director of Human Resources at (808) 956-3100.