

University of Hawaii  
REPORT OF WORK-RELATED INJURY/ILLNESS

**I. Employee's Statement (to be completed by Employee or WC Coordinator in consultation with Employee)**

Name: \_\_\_\_\_ Dept/College: \_\_\_\_\_

          Last                      First                      M.I.

Home Address: \_\_\_\_\_ Marital Status: Married ( ) Single ( )

   Street/P.O. Box

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

          City                      State                      Zip

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

          mo                      day                      year

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ a.m./p.m. (circle)

          mo                      day                      year

Time Began Work on Day of Injury: \_\_\_\_\_ a.m./p.m. (circle) Supervisor's Name: \_\_\_\_\_

Date Injury/Illness reported to Supervisor or WC Coordinator (College Personnel Officer): \_\_\_\_\_

Exact Address/Location where injury occurred: \_\_\_\_\_

List names and phone numbers of any witnesses to injury/illness:

Any outside employment? No [ ] Yes [ ] If yes, list name and address of employer:

Did you lose any time off from work? No [ ] Yes [ ] If yes, indicated dates: From \_\_\_\_\_ To \_\_\_\_\_

Fully describe how, when and where the injury occurred (e.g., I was in Hawaii Hall Room 5 moving a 60# box of copier paper from the bottom shelf to the hand truck when I felt a sharp pain.):

Identify body part and extent of injury/illness (e.g., muscle strain in lower back):

Identify the tools, equipment, or materials, if any, you were using at the time of the accident:

Identify any protective equipment you were using at the time of accident: \_\_\_\_\_

If you received medical treatment other than first aid, provide name and address of medical provider:

If you were hospitalized for this injury/illness, provide name and address of hospital:

Have you ever had a similar injury/illness? No [  ] Yes [  ] If yes, please explain and list names and addresses of previous medical providers who have treated you:

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*I hereby certify that the statements on this form are true and correct to the best of my knowledge.*

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Employee's Signature \_\_\_\_\_ E-Mail \_\_\_\_\_ Date \_\_\_\_\_

**II. Supervisor's Statement**

Date on which the injury/illness described above was reported to you: \_\_\_\_\_

Reason for delay, if any, in informing WC Coordinator:

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Is the Employee's description of his/her work assignment at the time of injury/illness accurate? Yes [  ] No [  ]  
If no, explain:

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Was the Employee performing the assigned duties and responsibilities at the time of injury/illness? Yes [  ] No [  ]  
If no, explain:

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Additional information (provide relevant information; e.g., special circumstances relating to the injury/illness, contextual information, etc.)

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Supervisor's Name (Print) \_\_\_\_\_ Supervisor's Signature \_\_\_\_\_ Phone No. \_\_\_\_\_

**III. Authorized Workers' Compensation Coordinator (Designated College PO/AO)**

Employee-Claimant Employment Information:

Position Title: \_\_\_\_\_ Date of State Hire: \_\_\_\_\_ Gender (circle): Male/Female

Payroll #: \_\_\_\_\_ BU: \_\_\_\_\_ Contract Type (circle): 9 /11/12 ERS Plan Type (circle): A0 A1 H0 H1 C0 Z0 Z1 B0 V0 R1

Type of Appointment (circle): Regular/Temporary/Casual/Emergency OR Part-Time (Hrs worked per week): \_\_\_\_\_

Employing Agency Code: 22-\_\_\_\_\_ Pay: \$ \_\_\_\_\_ Base Monthly OR \$ \_\_\_\_\_ Hourly

UH Payroll Account Code and % at time of injury:	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Reason for delay, if any, in submitting report to TRISTAR: \_\_\_\_\_

**Within 8 hours of a Death or 24 hours of a Catastrophic Event**, Supervisors/WC Coordinators are responsible to call the DLIR – HIOSH **AND** DLIR – DCD **AND** TRISTAR/ORM phone numbers (leave a voicemail message if no one answers) for the following events:

- DLIR – HIOSH within 8 hours of a death due to industrial injury or within 24 hours of work-related injury of 1 or more employees requiring in-patient hospitalization, amputation, loss of an eye, or property damage worth \$25,000 or more **AND**
- DLIR - DCD within 48 hours of a death due to industrial injury **AND**
- TRISTAR and ORM immediately upon notification of a work-related death/catastrophic event of an injury of 1 or more employees requiring in-patient hospitalization, amputation, loss of an eye, or property damage worth \$25,000

**Death/Catastrophic Event? No** \_\_\_ **Yes** \_\_\_ **Date of Death:** \_\_\_\_\_ **Date/Time UH Notified of Death:** \_\_\_\_\_

Date and Time DLIR–HIOSH (#1-808-586-9102) Notified of Death: \_\_\_\_\_

Date and Time DLIR – DCD (#1-808-586-9161) Notified of Death: \_\_\_\_\_

Date and Time TRISTAR (#1-808-470-0860 ext. 5212/5115/5120) Notified of Death: \_\_\_\_\_

Date and Time ORM (#1-808-956-8893/1-808-956-7243) Notified of Death: \_\_\_\_\_

Provide the Employee's Name, Date of Injury/Illness, Date/Time of Death (if applicable), and details of the event if speaking with a person. If leaving a voicemail message for HIOSH/DCD, leave your name, phone number and a brief summary of what happened without the employee's name. If leaving a voicemail message for TRISTAR/ORM, leave the Employee's Name, Date of Injury/Illness, Date/Time of Death (if applicable), and available details of the event.

Additional information (Provide any other relevant information; e.g., knowledge of concurrent employment if not otherwise indicated by Employee; special circumstances relating to the injury/illness):

*I understand that the Employer's Report of Injury/Illness must be submitted to DLIR by TRISTAR within seven (7) days of the Employee's notice to Employer in compliance with Chapter 386, HRS. The UH Form 79 (OHR) Report of Work-Related Injury/Illness and UH Form 42 (OHR), Computation of Average Weekly Wages for Temporary Disability Payments were timely submitted to TRISTAR by FileDrop to [tpa.support.fi@tristargroup.net](mailto:tpa.support.fi@tristargroup.net) by:*

_____ Authorized WC coordinator (print)	_____ WC Coordinator Signature	_____ Phone No.	_____ Date
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**FileDrop to: TRISTAR ([tpa.support.fi@tristargroup.net](mailto:tpa.support.fi@tristargroup.net)) and ORM–WC ([suzette@hawaii.edu](mailto:suzette@hawaii.edu))**  
**Original: WC Coordinator (do not file in employee's personnel folder)**