Procedure 6.5: Workplace Safety and Injury Reporting
Volume 6
Managing Office: Office of Human Resources
Effective Date: March 15, 2011
Revised: June 2014

I. GENERAL POLICY

Alabama A&M University ("AAMU" or "the University") strives to provide AAMU employees with a safe and healthful work place. To assist in this effort, employees are required to practice safe work habits. Employees must report known workplace hazards to their immediate supervisor and have knowledge of injury prevention tools (e.g., fire extinguishers, first aid kits, defibrillators, etc.) in their department. The purpose of the Workplace Safety and Injury Reporting Procedure is to notify University employees of the appropriate method to manage and report workplace injuries.

On-the-Job Injuries and On-the-Job Illnesses are not necessarily eligible for workers' compensation or other insurance benefits. Reporting a case to the Office of Human Resources or the Alabama State Board of Adjustment does not mean that AAMU or the employee was at fault or that a standard of the U.S. Occupational Safety & Health Administration was violated.

For the purpose of this Procedure the following definitions will apply:

1. *Accident* shall mean an unexpected and unforeseen event, happening suddenly and/or violently, with or without human fault.

2. *On-the-Job Injury* is defined as an injury resulting from an accident, event, or exposure in the work environment and arising out of and in the course of the employment. It shall not include an on-the-job-illness, except as provided in this Procedure.

3. *On-the-Job Illness* is defined as an illness resulting from the continuous and repeated exposure to hazardous materials documented to be dangerous to humans when the exposure is determined to be excessive or above permissible limits established by the manufacturer of the material or other credible sources such as the U.S. Occupational Safety and Health Administration. An on-the-job illness shall have the same meaning as an occupational disease. An on-the-job
illness does not include communicable diseases or infections typically transmitted by human contact. However, an exposure to a biologic hazard in an academic, clinical, or

research setting is considered an on-the job illness as long as the exposure arose out of and in the course of employment. Alleged work-related stress, anxiety, depression or other mental illness are not covered under this Procedure unless medical documentation states that it was produced or proximately caused by some physical injury to the body in conformance with this Procedure.

4. *Employee* is defined as full and part-time regular faculty and staff, and adjunct faculty; graduate student assistants; biweekly undergraduate student personnel; and AAMU temporary employees.

II. INJURY IN THE WORKPLACE

1. Reporting of Injuries with Alabama A&M University

Each employee is required to provide a written report to the Office of Human Resources within forty-eight (48) hours of an on-the-job illness or injury. To report work-related injuries and illnesses, the employee must use the *Alabama A&M University Injury or Illness Incident Report* form, which may be obtained on the Office of Human Resources Website at http://www.aamu.edu/human_resources/forms.aspx or in the Office of Human Resources (Attachment No. 1). The Office of Human Resources will maintain a basic log and summary of work-related injuries and illnesses for specified on-the-job injuries or illnesses as required by OSHA regulations.

a. Immediate Supervisor
All on-the-job- injuries or work-related illnesses regardless of their severity must be immediately reported to the employee's supervisor.

b. Office of Human Resources
All on-the-job- injuries or work-related illnesses regardless of their severity must be reported, in writing on the *Alabama A&M University Injury and Illness Incident Report* form, to the Office of Human Resources within forty-eight (48) hours of an on-the-job injury or illness. If injured employees are unable to complete the form, then their supervisor must do so on their behalf.

In the event that an on-the-job injury is not serious enough to warrant emergency room or private medical treatment, the employee may be referred to the AAMU Student Health Center. If the injury is serious enough to warrant emergency room treatment or private medical care, then the supervisor (or designee) will aid the employee in getting medical attention at one of the local emergency facility or from the employee's family doctor at the employee's election. The supervisor and other AAMU personnel are not required to personally transport an injured employee to a medical facility as calling an ambulance in a timely manner and ensuring that the individual is subsequently transported by the emergency personnel is sufficient assistance to the injured individual. If the injured employee is incapacitated or otherwise unable to elect a medical facility for treatment, then the supervisor (or designee) shall aid in securing transportation for the employee to a local emergency room. In either case, the employee will be personally billed for any medical services provided.

2. Reporting of Injuries with the Alabama State Board of Adjustment

All claims for charges related to an on-the-job injury or illness not paid for by the injured employee's private medical insurance may be filed by the individual with the State of Alabama Board of Adjustment. The injured employee is personally responsible for completing and filing the *Alabama Board of Adjustment "Claim for Personal Injury/Property Form*" (Attachment No. 2) as instructed by the Alabama Board of Adjustment. The "*Claim for Personal Injury/Property Form*" and instructions for filing a claim may be obtained on the Board of Adjustment website at http://bdadj.alabama.gov/pages/forms_instr.aspx or in the Office of Human Resources. Additional information regarding the Alabama Board of Adjustment is available at www.bdadj.alabama.gov. All claims filed with the Alabama Board of Adjustment are subject to the Board's review and will not necessarily result in payment to the injured employee.

III. INJURY LEAVE

Full-time employees sustaining a legitimate on-the-job illness or injury may be granted up to ten (10) business days of paid leave in association with any medically necessary recovery period from the work related injury or illness regardless of their current sick leave hours balance (e.g., ten (10) day grace period). The relevant Alabama law governing paid leave for police officers injured in the line of duty shall govern the amount of paid leave work days for which a certified police officer is eligible. If approved, days shall not be deducted from an injured employee's regular accumulated sick leave days during the ten (10) day grace period (or the time period as otherwise specified for police officers) for on-the-job illness or injury recovery periods.

i. Injured employee may elect to charge absences due to an on-the-job illness or injury to their sick leave thereby receiving full pay during their recovery period.

ii. All medically necessary absences from work that are associated with a work-related injury must be explained on the Medical Practitioner's Statement of Illness or Injury Form by a licensed physician as soon as practicable and preferably in advance, but no later than three (3) business days after the leave period begins.

iii. During the sick leave period, employees shall not receive salary in excess of 100% of regular salary. Any supplemental pay shall cease for the duration of sick leave.

iv. Provided that the ten (10) day sick leave grace period and/or use of personally accrued sick leave hours are approved, then the employee's salary shall continue as if the employee were performing regular duties.

v. If the employee is eligible for the Family and Medical Leave Act (FMLA)[1], then the on the job illness ten (10) days sick leave and FMLA will run concurrently. In accordance with FMLA, the employee is eligible for twelve (12) weeks (480 hours) of FMLA leave for medical purposes in a rolling twelve (12) month period. The twelve (12) month rolling period begins on the first day that the employee uses leave for the on the job injury.

vi. Sick leave days may be earned while the employee is out of service due to injuries that are job related provided that the employee is in an active leave status (e.g., sick leave).

vii. Employees may not engage in other form of employment for any employer or business, including personal businesses, during their medically necessary sick leave period for recovery of a workplace injury or illness.

viii. Upon the employee's return to work from injury leave, the employee must submit a work release notice from the medical practitioner to the Office of Human Resources and his/her supervisor.

ATTACHMENTS: (Updated June 2015)

No. 1 - *Alabama A&M University Injury and Illness Incident Report*
No. 2 – *Medical Practitioner's Statement of Illness or Injury Form*
No. 3 - *Alabama Board of Adjustment Claim for Personal Injury/Property Form*

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[1] An employee is covered by the FMLA if he or she meets the following eligibility requirements:

i. Has completed 12-months of cumulative employment (or 52 weeks if the work is intermittent); and,
ii. Worked for AAMU at least 1,250 hours*, including overtime, in the 12 months immediately preceding the date the FMLA leave will begin. Except for military leave, paid and unpaid leave is not counted as part of the 1,250 hours*; and,
iii. Has not already used the current calendar year's 12 week FMLA leave entitlement.

*Hours worked are not counted for Fair Labor Standards Act overtime exempt personnel. Exempt employees are automatically considered to have worked 1250 hours unless the work records clearly reflect otherwise.

Alabama Agricultural and Mechanical University
Office of Human Resources

Mailing Address: Human Resources, Alabama A&M University, Normal, AL 35762
Phone: 256.372.5835 Fax: 256.372.5881

Workplace Injury or Illness Incident Report

1. Full Name of Injured_____ Telephone No. (____)_____

2. Address_____ _____ _____ _____
   Street City State Zip

3. Date of Birth _____/_____/_____ Department _____

4. Gender ____ Male or _____ Female

5. Date Hired ____/____/____

6. Date of accident/injury ____/_____/____ Time of accident/injury _____

7. Date reported___/___/___ Person to whom accident /injury was reported _____

8. Where did the accident, injury or exposure occur? _____

9. How did the accident/injury occur? _____
   _____

10. List any tools, equipment, substances, machinery, etc. in use when the event occurred _____
    _____

11. Describe the nature and severity of the injury. What part of the body was affected and how it was affected; be more specific than "hurt", "pain", or "sore." *Examples*: "strained back"; "chemical burn, hand"; and "carpal tunnel syndrome."
    _____

12. What object or substance directly harmed the employee? *Examples*: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the accident, then please write Not Applicable.
    _____

13. What happened? Tell us how the injury occurred. *Examples*: "When ladder slipped on wet floor, employee fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; or "Worker developed soreness in wrist over time." _____

14. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples*: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."

15. Did the injury/accident involve exposure to blood borne pathogens (bodily fluids)?

☐ Yes ☐ No

16. Was the injury/accident witnessed?

☐ Yes ☐ No

If yes, name(s) address(es), phone number(s) of witness(es): _____

_____

17. Time injured employee reported to work on the day of incident. _____

18. Did the injured receive medical treatment? ☐ Yes ☐ No When? _____

19. If treatment was provided, state the name, address and phone number of the hospital or physician treating the individual. _____

20. Was the injured transported to: ☐ Physician ☐ Hospital ☐ Ambulance ☐ Self ☐ Another Person

21. If transported by another person or ambulance, give name, address and phone number of individual or list ambulance service._____

22. Was an Incident Report filed with Campus Police? ☐ Yes ☐ No

23. Was the injured employee treated in an emergency room? ☐ Yes ☐ No

24. Was the injured employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

25. How long was the injured employee off work due to the incident or will be off?_____

26. Has the employee returned to work? ☐ Yes ☐ No

27. If the employee died, when did death occur? _____/_____/_____

_____ _____

Name of person completing this form (please print) Signature

_____ _____

Title: Date:

Alabama Agricultural and Mechanical University
Office of Human Resources

Mailing Address: Human Resources, Alabama A&M University, Normal, AL 35762
Phone: 256.372.5835 Fax: 256.372.5881

Workplace Injury or Illness Incident Form
Medical Practitioner's Statement of Illness or Injury

Medical Practitioner: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproduction services.

Name of Employee/ Patient:_____ Date of Birth: _____

Practitioner's Statement (Please type and use additional sheets if necessary)

Practitioner's Name:_____

Practitioner's Specialty: _____

Mailing Address:_____

_____

Telephone number:_____ Fax Number:_____

1. Nature of illness or injury (layperson's terms):_____

   _____

   _____

2. Date upon which you first examined the patient for this condition:_____

3. Anticipated date upon which the patient will be fit to return to work:

   Limited Duty:_____ Full Duty:_____

_____
Practitioner's Signature Date

Return to the Office of Human Resources via U.S. mail to
Human Resources, Alabama A&M University, Normal, AL 35762
or
Fax to 256.372.5881

INSTRUCTIONS FOR ALABAMA STATE BOARD OF ADJUSTMENT
CLAIM FOR ON THE JOB INJURY

www.bdadj.alabama.gov

NOTE: Claims must be presented to the Alabama State Board of Adjustment within one year after the date of the injury or within two years for claims for injury resulting in death. Each question must be answered. If all questions are not answered, the claim will not be accepted. Forms must printed in ink or typed. All supporting documentation must be submitted on 8 ½ x 11 paper front side only.

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Claim forms must be accompanied by all of the required documentation or your claim will be returned requesting further information. Any delays could cause the dismissal of your claim.

- **MAIL COMPLETED FORMS TO**:
  Alabama State Board of Adjustment
  600 Dexter Avenue, Suite E-302
  Montgomery, AL 36104
- **FORMS MAY BE DELIVERED TO:**
  Alabama State Board of Adjustment
  State Capitol Building, Suite E-302
  Montgomery, Alabama
- Telephone Numbers: (334) 242-7175 Fax: (334) 242-2008

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1. Enter the name of the State Agency you are filing your claim against. (Example: Department of Transportation, Department of Education, etc.)

2. Enter your personal information. Enter your Name, Address, Telephone Number(s), E-mail Address, the last four digits of your Social Security Number or the last four digits of your FEIN if a business. Claims without the last four digits cannot be processed and will be returned to the Claimant.

3. If you have an attorney, enter your attorney's information. (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

4. Enter the facts of the claim:

   A. Enter the date the injury occurred.
   B. Enter the date notified by employer of your privilege to file a claim with the Board of Adjustment.
   C. Enter the location and address where the injury occurred. (Example: Lunchroom at City Elementary, City, Alabama 36000)
   D. A statement of facts describing the injury and the events surrounding the injury. Documentation must accompany the claim for proof of the injury. Provide an official accident or incident report showing the date of the injury. The report must be signed by a supervisor or some other official. Any other evidence to prove that the incident upon which the claim is based took place must be attached. (Example: Dated and signed witness statements.)

5. If this was an on-the-job injury, check yes. If no, use Personal Injury Form. This form can be found on the Board of Adjustment web site shown at the top of this page.

6. Employer Information:

   A. Enter the name, address and telephone number of your employer.
   B. Enter your job title at the time of the injury.
   C. Enter your supervisor's name at the time of the injury.
   D. If you are still employed with employer listed in 6A check the "Yes" box.
   E. If you are no longer employed with employer listed in 6A, enter your last date of employment.

7. Medical Expenses: Enter all medical expenses incurred as a result of the injury. Include additional sheets if necessary. List each health care provider, including pharmacy, and the amount charged by each. You must provide evidence (itemized bills) to show what treatment was provided, when it was provided, and the charge, as well as evidence of insurance filing and payments (insurance company summary sheets). Board of Adjustment will not make awards for expenses paid by private insurance. If claimant is not covered by insurance, this should be clearly stated.
   A. Total of Medical Expenses Claimed

8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid directly to you.
   A. Total Payments Made to You from All Insurance Companies

9. Medical Disability: If you are claiming medical disability, you MUST complete this section.

   A. If you are claiming damages for permanent disability, check "Yes"; otherwise, check "No.
   B. If you have claimed compensation for permanent disability from any source, such as Social Security Disability, Workman's Compensation, etc., check "Yes"; otherwise, check "No".
   C. Enter the amount you are seeking for permanent or total disability.
   D. Describe the permanent disability. Evidence (usually a letter, statement, or report from physician) that claimant has reached maximum medical improvement "MMI" and is left with a disability stated in percentage of physical impairment to the whole body or part of body is involved (arm, leg, finger, etc.).

10. Wages: If you are claiming lost wages and/or compensation for leave used, list each separately. Evidence from doctor or other healthcare provider that claimant was unable to work because of the accident/injury stated, verification from the employer of the time lost from work or the leave deducted and verification from the employer of the claimant's rate of pay at the time of the accident/injury.

    A. Enter the amount of wages you lost due to the injury. Circle whether the amount you have entered is for hours, days or weeks. (Example: $25 for 2 hours)
    B. Enter the amount of leave used. (Example: 16 hours for 2 days)
    C. Enter your rate of pay at the time of your injury. Check the box indicating whether the amount is per hour, day, or week. (Example $12.50 per hour)
    D. Enter the total of wages lost due to the injury.

11. Enter any miscellaneous expenses associated with the personal injury, such as damages to automobile, eyeglasses, mileage, etc. Note: If claiming mileage, use the Mileage Log which is listed on the web site, www.bdadj.alabama.gov, as Alabama State Board of Adjustment Mileage Log.

    A. Provide the total amount of miscellaneous expenses claimed.
    B. If any of the listed expenses are covered by insurance, please check "Yes"; otherwise, check "No".
    C. If you answered "Yes" in Item 11.B., list the amount of insurance coverage and your deductible. (For damages to personal property, it will be necessary to provide a copy of your insurance declaration page which indicates your amount of coverage and your deductible.)

12. Enter the GRAND TOTAL amount you are claiming for all items described in Items 7.A., 9.C., 10.D., and 11.A.

13. Sign the claim form in the presence of a Notary Public, print your name and have the notary complete the verification section.

ALABAMA STATE BOARD OF ADJUSTMENT
CLAIM FOR PERSONAL INJURY - ON THE JOB

See Page 1-2 of this form for instructions. Each number on the form corresponds with numbers on instruction sheets. Read all instructions carefully to ensure your claim is not returned for additional supporting documentation. See INSTRUCTIONS for mailing or hand delivering this form to the Board of Adjustment (Page 1).	**DO NOT WRITE IN THIS SPACE. FOR BOARD OF ADJUSTMENT USE ONLY.** **Claim No.:**_____

1. Name of the Department or Agency of the State of Alabama against which you are making this claim:

   _____

2. Claimant's Information:

   Name: _____

   Street Address or P.O. Box: _____

   City, State, Zip Code: _____

   E-mail Address: _____

   Home Telephone No.: _____ Office Telephone No.: _____

   Cellular Telephone No.: _____Fax No.: _____

   Claimant's Last Four Digits of Social Security No. or last four digits of Business FEIN:

   SSN: XXX-XX-_____ FEIN: XX-XXX _____

3. Claimant's Attorney: (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

   Attorney Name: _____

   Street Address of P.O. Box: _____

   City, State, Zip Code: _____

   E-mail Address: _____

   Office Telephone No.: _____Fax No.: _____

4. Facts of Claim:

   A. Date of Injury: _____

   B. Date notified by employer of your privilege to file a claim with Board of Adjustment:_____

   C. Location/Address of Injury: _____

   D. Statement of Facts (Describe the injury and the events surrounding the injury): _____

   _____

   _____

   _____

5. Was this an on-the-job injury? ☐ Yes ☐ No

6. Employer Information (If on-the-job injury):

   A. Name, Address & Telephone Number of Employer: _____

   _____

   _____

   B. Job Title at the Time of the Injury: _____

   C. Name of Supervisor at the Time of the Injury: _____

   D. Are you still employed with employer listed in 6.A.? ☐ Yes ☐ No

   E. If no, what was the date of your last day of employment? _____

7. Medical Expenses (List each health care provider, including pharmacy, and the amount charged by each): Include additional sheets if necessary:

Provider	Amount of Expense

   A. Total of Medical Expenses Claimed: _____

8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid directly to you:

Name of Insurance Company (Includes Medicare, Medicaid)	Amount Paid To You

   A. Total Payments Made To You from All Insurance Companies: _____

9. Medical Disability:

   A. Are you claiming damages for permanent disability? ☐ Yes ☐ No

   B. Have you claimed compensation for permanent disability for this injury from any other source, such as Social Security Disability, Workers Compensation, etc.? ☐ Yes ☐ No

   C. What is the amount you are seeking for permanent or total disability? _____

Claimant's Name_____

Medical Disability (Continued):

D. Describe the permanent disability: _____

_____

_____

10. Wages (If you are claiming lost wages and/or compensation for leave used, list each separately):

A. Amount of lost wages: _____ for _____ hours/days/weeks

B. Amount of leave used: _____ for _____ hours/days/weeks

C. Rate of Pay at time of Injury: _____ per ☐ Hour ☐ Day ☐ Week

D. Total Wages Claimed: _____

11. Miscellaneous Expenses: (List other expenses you are claiming and the amount for each such as damages to auto, eyeglasses, mileage, etc.) If claiming mileage, use the Mileage Log which is listed on the web site, www.bdadj.alabama.gov, as Alabama State Board of Adjustment Mileage Log.

Item	Amount of Expense

A. Total Amount of Miscellaneous Expenses Claimed: _____

B. Are any of the expenses listed above covered by insurance? ☐ Yes ☐ No

C. If yes, list amount of coverage and deductible amount:

Amount of Coverage: _____

Comprehensive Deductible: _____ Collision Deductible: _____

12. What is the **GRAND TOTAL** amount you are claiming for all items described in Items 7.A., 9.C., 10.D., & 11.A._____

13. Signature of Claimant/Authorized Representative: _____

Please Print Name: _____

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VERIFICATION

STATE OF _____

COUNTY OF _____

Before me, a Notary Public in and for said state and county, personally appeared the person whose name is signed above who being made known to me and being duly sworn to give true testimony, affirmed that all of the above stated facts are true and correct.
Sworn and subscribed before me this _____ day of _____, 20 _____

Signature of Notary Public _____

AFFIX SEAL Printed Name _____