KENNEBEC VALLEY COMMUNITY COLLEGE		
Policy #: 5.02	**Effective:** 08/24/05	**Replaces:** 02/27/03

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.

KENNEBEC VALLEY COMMUNITY COLLEGE

REPORT OF STUDENT INJURY OR ILLNESS

STUDENT INFORMATION

_____ _____ _____ _____
Last Name First Name MI SS#

_____
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: Hospital Name and Address:

_____ ❑ First Aid _____
_____ ❑ Hospital _____
_____ ❑ Emerg. Room _____
_____ ❑ Out-patient _____

(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:

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

_____ Campus Office: _____

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

KENNEBEC VALLEY COMMUNITY COLLEGE

REPORT OF VISITOR INJURY OR ILLNESS

VISITOR INFORMATION

_____ _____ _____ _____
Last Name First Name MI SS#

_____
Address - Number and Street

_____ _____ _____
City State Zip

_____ _____
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: _____

KENNEBEC VALLEY COMMUNITY COLLEGE

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.