UCONN HEALTH

Supervisor's Guide to Completing Workers' Compensation Form DAS WC-207

Supervisors are responsible for completing the DAS WC-207 form when an employee reports an injury. The information documented on this form is used to determine the entitlement benefits.

1. **Speak** with the injured employee to obtain facts of the incident.
2. **Call** 1-800-828-2717 to report the injury to Gallagher Bassett, immediately upon completion of the form. *DO NOT WAIT FOR DOCTORS' REPORTS*
3. **Fax** the form to Human Resources at 860-679-4660 by the end of shift.

INSTRUCTIONS ON COMPLETING THE WC-207

Item 1	Employees stationed at UConn Health Facilities shall use, "UHC72000." Employees stationed at Correctional Facilities shall use, "CMHC7200."
Item 2	Fill in the employee's department name.
Item 3	Fill in the employee's social security number. If unknown, inform Gallagher Bassett.
Items 4-9	Fill in the employee's information.
Item 10	Fill in the employee's job title.
Item 11	Fill in the employee's date of hire.
Items 12- 13	Fill in the date and time according to the employee's recollection of the incident.
Items 14- 15	Fill in the date and time when you were first made aware of the incident.
Item 16	Fill out the employee's work start time on the date of injury.
Item 17	Check the appropriate box to indicate whether or not there was a fatality.
Item 18	If item 17 was answered "Yes", fill in a date of fatality. If "No", fill in, "N/A".
Items 19- 23	Fill in information in regards to the employee's description of the incident. Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of the body injured (back, arm, etc.); also note the tools, equipment, machines, objects, or substances involved.
Items 24-27	Fill in the fields with the appropriate medical treatment information.
Item 28	Fill in witness information, if available. Please include contact information.
Items 29-30	Fill in contact information for the supervisor to whom the claim was reported.
Item 31	Sign, print name, and date the form.
Item 32	Fill in the date when this injury was phoned into Gallagher Bassett.
	Gallagher Bassett will provide a reference number. Note this information in the field, "TPA Reference No." at the top of the form

TPA Reference No.	Agency use only
555-333-1234	Incident No.:
	Claim No.:

DAS WC-207

First Report of Injury

The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim forms to the Human Resources/Workers' Compensation Office within 24 hours.

Rev 02/2017

1. Agency Location Code	2. Division/Region			
UHC72000	JDH Intensive Care Unit			
3. SSN	4. Employee Number	5. Name of Injured Worker (First) (Last) (MI)		
999-99-9999	1234567	Jane Doe, M		
6. Home Address (City or Town) (State) (Zip)		7. Home Telephone	8. Date of Birth	9. Sex
263 Farmington Ave. Farmington, CT 06032		860-679-2426	01/01/1970	F
10. Job Classification (Title)		11. Date of Hire	12. Date of Incident	13. Time of Incident
Staff Nurse CN2		05/15/2012	01/01/2018	1:33PM
14. Time Employer Notified	15. Date Employer Notified	16. Time Injured Worker Began Work 7:30 ■ AM ☐ PM	17. Was Injury Fatal? ☐ YES ■ NO	18. Date of Fatality
1:38PM	01/01/2018			N/A

19. How Did the Injury Occur?

Employee states that she was assisting another nurse reposition a patient. The employee states that she felt immediate pain in her right wrist after rolling the patient's torso towards herself. The employee went to Occupational Medicine for a check up and was returned to work without any restrictions.

20. Type of Injury	21. Body Part(s) Affected
Strain/Sprain	Right wrist
22. Did Injury Occur on Employer Premises? ■ YES ☐ NO	23. Location Injury Occurred: ICU Room #121
24. Injured Worker Seeking Medical Treatment ■ YES ☐ NO If Yes Complete Questions 25-27	25. Medical Care Provided By: (Physician Name and Address) Dr. Moore, Occupational Medicine. 263 Farmington Ave. Farmington, CT 06032
26. Was Injured Worker Treated in an Emergency Room? ☐ YES ■ NO	27. Was Injured Worker Hospitalized Overnight as an In-Patient? ☐ YES ■ NO

28. Were There Any Witnesses to the Injury? ■ YES ☐ NO (If yes, give name, address, and phone)

Mary Brown, 263 Farmington Ave. Farmington, CT 06032, 860-679-0000

29. To What Supervisor Was Injury Reported? (Name) (Title)

Amy Smith, ICU Supervisor

30. Supervisor Contact Info Please Print	Name: Amy Smith
	Work Phone: 860-679-0010
	Best Time to Contact: Mon - Fri, 7:00-4:30

31. Signature of Supervisor (or other Designated Authority)	PRINT NAME:	DATE:
A Smith	Amy Smith	01/01/2018

32. Date Injury Phoned In To 800-828-2717: 01/01/2018

Supervisors Report All Injuries - Call 1-800-828-2717