



OCCUPATIONAL INJURY / ILLNESS REPORT

Employee First Report of Injury (SU-17A)

Status (*check one*)

- SLAC employee
- Subcontractor
- Student / visitor
- Temp personnel from agency
- Non-employee experimenter / user
- Other (*explain*)

SLAC employees: You must complete this form as soon as possible, but **no later than 24 hours** after the onset of a work-related injury or illness. This form is usually completed at SLAC Medical and its completion is required even if no medical treatment is sought.

All others: The injured party is strongly encouraged to complete this form. If this is not possible, the SLAC point of contact (POC) or university technical representative (UTR) must also complete the SU-17A and submit it as an attachment to the required Incident Investigation Form (SU-17B).

For additional information see: Human Resources <http://www-group.slac.stanford.edu/hr/wc/>

1. INJURED PERSON IDENTIFICATION

Name (<i>first / initial / last</i>):		Date of hire:	Time at this job (<i>if applicable</i>):	
SSN (<i>last 4 digits</i>):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Bargaining unit: <input type="checkbox"/> Yes <input type="checkbox"/> No	Job title:	
Home address:		Supervisor:		
City / state / zip code		Time you started work on date of incident:		
Home phone:		Work phone:	Mailstop:	

2. INJURY OR ILLNESS DESCRIPTION

Incident date (<i>mo/day/yr</i>):	Time it occurred (<i>hh/mm</i>):	Directorate / dept:	Location (<i>building, room no., in / outside</i>):	Date reported:
Injured body part(s) (<i>be very specific</i>):				
Injury type (<i>check all that apply</i>)				
<input type="checkbox"/> No injury	<input type="checkbox"/> Fracture	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Burns / scalds	
<input type="checkbox"/> Strain / sprain	<input type="checkbox"/> Repetitive stress injury	<input type="checkbox"/> Amputation	<input type="checkbox"/> Exposure to (<i>specify</i>):	
<input type="checkbox"/> Laceration / cut	<input type="checkbox"/> Insect bite / sting	<input type="checkbox"/> Foreign body in eye	<input type="checkbox"/> Other (<i>specify</i>):	
<input type="checkbox"/> Scratch / abrasion	<input type="checkbox"/> Splinter	<input type="checkbox"/> Internal injury		
<input type="checkbox"/> Bruising	<input type="checkbox"/> Exposure to heat / cold	<input type="checkbox"/> Reaction to chemical exposure		
First treating physician (<i>name</i>):		Incident witness(es):		
Located at (<i>address</i>):				
Date of visit:				

3. INCIDENT DESCRIPTION

1) What were you doing?

(Continued on page 2.)

Incident Investigation: Employee First Report of Injury (SU-17A)

3. INCIDENT DESCRIPTION, continued

- 2) How did the incident causing injury or illness happen?
- 3) Describe equipment, materials and chemicals being used when incident or exposure occurred.
- 4) List any contributing factors (*such as improper tools, insufficient training, or lack of personal protection equipment*).
- 5) How could the accident have been avoided? (*Examples include asking for help to lift a heavy object or sizing up a load more accurately.*)

(Continue on an extra sheet if necessary.)

4. STATEMENT SIGNATURE

I refuse treatment against medical advice as declared in section 5 below. (*If you refuse treatment you must also complete Section 5.*)

Signing this form does not necessarily constitute acceptance of a workers' compensation claim. *If you are a SLAC employee and your injury becomes more than a first aid case because you need extended medical treatment, complete a DWC-1 Workers' Compensation claim form at SLAC Medical.*

The provided information is true and correct to the best of my knowledge and belief.

Injured person's signature: _____ Time: _____ Date: _____

5. REFUSAL OF TREATMENT AGAINST MEDICAL ADVICE (*complete only if refusing medical treatment*)

To decline medical care against medical advice (AMA) the injured person must meet all of the following criteria:

1. Be an adult (*18 or over*)
2. Exhibit no evidence of altered level of consciousness and not be under the influence of alcohol or drugs that impair judgment
3. Understand the nature of the medical condition as well as the risks and consequences of refusing care

Acknowledgment of Information: I have been advised that medical assistance on my behalf is necessary, and that refusal of said assistance could be injurious to my health, and under certain circumstances risks may include disability and/or death. I have been advised to discuss my medical complaints with my regular health care provider as soon as possible. Nevertheless, I refuse to accept treatment or transport to a medical facility and assume all risks and consequences of any decision.

Release of Liability: By signing this form, I am releasing SLAC, Stanford University, SLAC's Occupational Medical Subcontractor, responding emergency medical service (EMS) agency(ies) of any liability or medical claims resulting from my decision to refuse the medical care/transport offered.

I have read and understand the "Acknowledgment of Information" and "Release of Liability".

Name: _____ Signature: _____ Date: _____

If you change your mind or symptoms from an injury that happened at work occur after SLAC business hours, you may obtain emergency medical treatment wherever necessary (for example, a medical facility close to your home). You must report the injury to SLAC Medical as soon as possible the next day.

Signature witnessed by (*print*): _____ Signature: _____

Address: _____ Phone number: _____

(EMS / SLAC MEDICAL COMPLETES BELOW THIS LINE)

Refused to sign, reason (*if applicable*):

Interpreter name (*if applicable*):

Released injured party into the care or custody of :

Self Spouse Co-worker Friend Parent Guardian Law enforcement: Agency(Badge No. _____) Other:

Name (*print*)

Signature

Date