ARIZONA DEPARTMENT OF CORRECTIONS

Employee/Supervisor Report of Industrial Injury

You MUST call in your claim before the end of the shift in which the injury occurred. 602-542-WORK or 1-800-837-8583

DOA Risk Management: 100 N. 15th Ave. Suite 300, Phoenix AZ 85007
Policy: W/C #520

Date and Time of Call _____ **Case Number from Log** _____

1. Date of Injury	2. Time of Injury	3. Work Location *(Division, Institution, Unit)*	4. Date Supervisor Notified
5. Name of Supervisor Notified		6. Date Hired	7. Supervisor Work Phone ( )
8. Injured Employee's Name *(Last, First M.I..)*	9. Social Security Number	10. EIN	11. Date of Birth
12. Home Address *(Street)*	13. City / 14. State	15. Zip Code	16. Home Phone Number ( )
17. Work Phone Number ( )	18. Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married	19. Sex ☐ Male ☐ Female	20. Job Title
21. Work Hours From _____ To _____	22. Regular Days Off ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday		23. Shift ☐ Days ☐ Swings ☐ Grave Yard
24. Specific Address/Location of Accident			25. Did the Injury Occur on Employer's Premises? ☐ Yes ☐ No
26. Nature of Injury: *(cut, bruise, sprain, etc.)*	27. Part of Body Injured: Side Injured ☐ Left ☐ Right ☐ Both		28. Fatal ☐ Yes ☐ No
29. Seen by Physician ☐ Yes ☐ No	30. Name of Physician or Other Health Care Professional		Phone Number
31. Physician/Facility Address			
32. Was Employee Hospitalized Over Night As An In-Patient? ☐ Yes ☐ No	If Yes, Name and Address of Hospital		
33. Specify Machine, Tool, Substance, or Object Connected With Incident?			
34. How did the incident happen? What were you doing before the incident?			
35. What Were You Doing When Injury Occurred? *(load truck, walking, etc.)*	36. If Caused By Other Employee, Give Name/ Work Location		
37. Were Personal Items Destroyed? If So, What? ☐ Yes ☐ No			38. On Overtime When Injured? ☐ Yes ☐ No
39. Stop Work Immediately? ☐ Yes ☐ No	40. Did anyone Witness The Accident? ☐ Yes ☐ No *(If yes, give name)*		

AUTHORIZATION OF LEAVE OTHER THAN SICK LEAVE - I hereby authorize the Department of Corrections, Central Office Payroll, to deduct compensatory, holiday and annual leave upon exhaustion of my sick leave balance and I attest that the above statements are true and correct, to the best of my knowledge

41. Injured Employee's Signature		42. Date
43. Supervisor's Name	44. Supervisor's Signature	45. Date

NOTE: Supervisors must complete this form when injured employee is unavailable
Form must be faxed to the OHU during shift when the incident occurred

NOTE: The Employee/Supervisor Report of Industrial Injury (519-2) must be completed by the employee or the employee's supervisor before the end of the shift in which the injury occurred. The Employee/Supervisor Report of Industrial injury (519-2) must be signed by the injured employee's supervisor and filed with the Occupational Health Unit.

INSTRUCTIONS FOR COMPLETING 519-2

1. Exact date of injury
2. Time injuryoccurred *(i.e., 8:00 a..m. or 1:00 p.m.)*
3. Injured emploee's work location *(i.e., Offender Operations, ASPC-Tucson, Rincon)*
4. Date supervisor notified Injured employee's date of birth
5. Name of supervisor notified employee's work location
6. Injured employee hire date Injured employee's shift
7. Supervisor work number

8-11. Injured employee's name, social security number, employee identification number, date of birth

12-20. Injured employee's home address *(City, State, Zip Code)*, home phone number, work phone number, marital status, sex, job title

21-23. Injured employee's work hours, regular days off, shift

24. Specify exact location of where the accident occurred
25. Did accident occurr on employer's premises?
26. State type of injury *(strain, cut, bruise, broken bone, burn, etc...*

27-28. List part(s) of body *(arm, finger, leg, etc.)*; side injured *(left, right, both)*, fatal (yes, no)

29-31. Did the injured employee go to a doctor or medical facility, if yes, give name, address and telephone number

32. Was the injured employee hospitalized, if yes, give name and address of the hospital
33. Specify type of machine, tool, substance or object connected to incident *(i.e., dolly, razor knife, etc.)*
34. Describe in detail how the incident happened and what you were doing just before the incident.
35. Describe what you were doing when the injury occurred *(i.e., loading a truck, opening boxes, etc..)*
36. Give name/work location if another individual caused the incident
37. Personal items damaged or destroyed *(clothing, etc.)*
38. Was the injured employee working overtime at the time the injury occurred
39. Did the injured employee stop work immediately after getting injured
40. List any witnesses to the injury

41-42. Injured employee signs and dates if he/she agrees to the statement above signature line

43-45. Signature and date of supervisor notified of the injury

WORKERS' COMPENSATION EARLY CLAIMS NOTIFICATION 24-HOUR HOTLINE
602-542-WORK (9675) OR 1-800-837-8583

The injured employee or the supervisor must call in to the Early Claims Notification Hotline and answer the following:

1. State your name, and the injured employee's agency, work location and phone number.
2. State the name, address, and telephone number of the injured employee.
3. What is the injured employee's social security number?
4. What is the name and daytime telephone number of the employee's supervisor?
5. Describe how the incident occurred.
6. What is the date that the employee was injured?
7. Have you sought or are you going to seek medical treatment? Yes or No
8. Who will provide the treatment?
9. Describe the injury and part of the body that was injured.
10. Please state the name of any witnesses to the injury.
11. Do you anticipate missing time from work?
12. If the incident was the fault of someone else, please state the person's name, address and telephone number.