Cannon Cochran Management Services, Inc. (CCMSI)
100 Quannapowitt Parkway, Suite 201
Wakefield, MA 01880
Fax (781) 246-3425

Accident Report

OSHA Form 301

Please print clearly or type

For Office Use Only
Claim #:
Priors: YES ☐ NO ☐

CCMSI (781)-683-1000

TO BE COMPLETED BY INJURED EMPLOYEE

Name | Home Telephone Number ( ) |
Home Address | Work Telephone Number ( ) |
City | State | Zip | Date of Birth / / | Harvard ID Number

Date of Injury / /

Time Shift Started am/pm

Time Shift Ended am/pm

Time of Injury am/pm
☐ Check if cannot be determined

Gender
☐ Male
☐ Female

Building (example: Holyoke Center or Gordon Hall)

Specific location where injury occurred

What were you doing immediately prior to the injury? *[Describe the activity, as well as the tools, equipment, or material being used. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."]*

What Happened? Tell us how the injury occurred. *[Examples: "When ladder slipped on wet floor, fell 20 feet"; "Developed soreness in wrist over time."]*

What object, substance or motion directly injured you? *[Examples: "concrete floor"; "chlorine"; "radial arm saw."* If this question does not apply to the incident, leave it blank.]

What was the injury or illness? [*Tell us the part of the body that was affected and how it was affected. Examples: "strained back"; "chemical burn, right hand"; "carpal tunnel syndrome."]*

Could this injury result in HIV infection? ☐ Yes ☐ No *[To be eligible for the HIV Benefit Plan, all work-related incidents that could result in HIV infection must be called into the Disability Claims Unit (495-9054) and followed by authorized HIV blood testing within 5 calendar days of the incident.]*

Information about the physician or other health care professional

Doctor/Hospital
Address
City | State | Zip

Witness 1. Name:
Telephone #: ( )

Witness 2. Name:
Telephone #: ( )

Signature of injured employee | Today's Date / /

TO BE COMPLETED BY THE SUPERVISOR TO WHOM THIS INJURY WAS REPORTED

Has employee lost more than 4 hours from work as a result of this alleged injury? ☐ No ☐ Yes ☐ Unknown

If yes, submit current job description & list dates out | Has employee returned to work? ☐ No ☐ Yes, on

Date you first knew employee was allegedly injured at work? / / | If employee died, when did death occur? Date of death / /

Print Name | Telephone Number ( )

Signature | Today's Date / /

TO BE COMPLETED BY DEPARTMENT

33 Digit Payroll Code

TUB	ORG	OBJECT*	FUND	ACTIVITY	SUB-ACT	ROOT

*Object code required

Department Name and Unit

Address of Department (including city)

Employee's Job Title | Date of Hire / / | Union Code

Scheduled # of hours/week | Scheduled days off

Pay Rate: $ /hour | Blended Rate? (check if yes) ☐ | Multiple Jobs? (check if yes) ☐

Payroll Coordinator | Telephone Number ( )

This section completed by (print name) | Telephone Number ( )

Signature | Today's Date / /