***All fields on the form must be completed**

Send Completed Claim Form to: Cannon Cochran Management Services, Inc. (CCMSI) 100 Quannapowitt Parkway, Suite 201, Wakefield, MA 01880 Fax: (781) 246-3425	**Harvard University** **Accident Report** **OSHA Form 301**

General Information	
Location: Choose an item.	**Location2:** Choose an item.
Date of Loss: Click here to enter a date.	**Time of Loss:** Click here to enter text.

Claimant	
Name: Click here to enter text.	**HUID:** Click here to enter text.
Address1: Click here to enter text.	**Home Phone:** Click here to enter text.
Address2: Click here to enter text.	**Work Phone:** Click here to enter text.
City, State, Zip: Click here to enter text.	**Home Email:** Click here to enter text.
Date of Birth: Click here to enter a date.	**Work Email:** Click here to enter text.
Marital Status: Choose an item.	**Gender:** Choose an item.

Client Specific Fields for WC							
TUB: Choose an item.							
Empclass: Choose an item.							
Department: Click here to enter text.							
Employment: Choose an item.							
Time Shift Started: Click here to enter text.							
Time Shift Ended: Click here to enter text.							
EE Lost More Than 4 hours of Work: Choose an item.							
How Many Hours Lost: Click here to enter text.							
Pay Per Hour: Click here to enter text.							
Multiple Job Indicator: Choose an item.							
Blended Rate: Choose an item.							
Pay Schedule: Choose an item.							
Weekly Schedule:	**Mon** ☐	**Tues** ☐	**Wed** ☐	**Thurs** ☐	**Fri** ☐	**Sat** ☐	**Sun** ☐
Hours Worked per Week: Click here to enter text.							
Return to Work Date: Click here to enter a date.							
Supervisor Name: Click here to enter text.							
Supervisor Phone: Click here to enter text.							
Location Where Accident Occurred: Click here to enter text.							

***All fields on the form must be completed**

Incident Information		
Loss Cause: Choose an item.		
Loss Type: Choose an item.		
Body Part: Choose an item.		
Date Reported: Click here to enter a date.		
Accident State: Choose an item.		
State of Jurisdiction: Choose an item.		
Accident Occurred on Harvard Premises: Choose an item.		
Accident Description (50 character limit): Click here to enter text.		
Other Relevant Claim Information: Click here to enter text.		
Initial Medical Treatment: Choose an item.		
Claimant Was Directly Compensated:	☐ **Yes**	☐ **No**

Witnesses	
Name: Click here to enter text.	**Title:** Click here to enter text.
Email: Click here to enter text.	
Phone: Click here to enter text.	**Alternate Phone:** Click here to enter text.
Name: Click here to enter text.	**Title:** Click here to enter text.
Email: Click here to enter text.	
Phone: Click here to enter text.	**Alternate Phone:** Click here to enter text.

Workers' Compensation/Jones Act Only	
Job Code: Choose an item.	
Lost Time: Choose an item.	**Date Last Worked:** Click here to enter a date.
Returned to Work: Choose an item.	
Returned Light Duty Date: Click here to enter a date.	
OR Returned Full Time Date: Click here to enter a date.	
Employee Died Because of Injury: Choose an item.	

Authorization	
Completed By: Click here to enter text.	**Date:** Click here to enter a date.
Title: Click here to enter text.	**Phone:** Click here to enter text.