

# WORK-RELATED INJURIES POLICY

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## **Section 1 - Policy**

1. The University believes that the safety and well being of employees, faculty members, and AUBMC residents<sup>1</sup>, is a major consideration in the operation of all facilities and that continuous effort should be exercised to observe safety rules designed to prevent work-related injuries.
2. Legislative Decree No. 136<sup>2</sup> of September 16, 1983 applies to personnel governed by Labor Law. Thus, if certain employees<sup>3</sup> suffer work-related injuries, they will be eligible for disability and medical benefits as provided for in said decree, but they are not entitled to invoke any legal provisions other than those contained in the aforementioned decree.

It is to be noted that said decree also addresses the case of death resulting from a work-related injury and the compensation therefore.

3. The law does not apply to subcontracted workers and excludes, among other things, accidents, injuries, or death resulting from<sup>4</sup>:
  - a. The deliberate fault or negligence on the part of the employee.
  - b. Deliberate acts, self-inflicted injuries or death, or while under the influence of alcohol or drugs.
  - c. The use of explosives.
  - d. Acts of war, civil commotion, exposure to radioactivity, or natural disasters.

## **Section 2 - Definitions of Work-Related Injury**

1. As defined in Legislative Decree No. 136 of September 16, 1983, a work-related injury is a sudden bodily injury caused by an external agent at the occasion of, or as a result of, the performance of the work contract.
2. Injuries sustained by employees traveling to or from their work place in a direct and normal route are considered to be work-related injuries. The same applies where the employer provides transportation.

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<sup>1</sup>Although AUBMC residents are not employees of the University, all references to employees in this policy shall, for the purpose of the interpretation of this policy, be construed to include residents, except where the context otherwise provides. Likewise, student and academic references shall also be construed to include AUBMC residents.

<sup>2</sup> For information regarding Decree No. 136, contact EHSRM.

<sup>3</sup> Faculty members and AUBMC residents are not covered by Labor Law.

<sup>4</sup> For a complete listing of exclusions, contact EHSRM.

### **Section 3 - Reporting Procedures**

1. Employees must immediately report an injury, no matter how seemingly insignificant, to their supervisors.

Failure to report a work-related injury in a timely manner may result in the denial of benefits under the Workmen's Compensation Law.

2. Upon being advised of the incident/occurrence/occurrence, the supervisor should report immediately to the scene of the occurrence to assure, if need be, first aid attention, address any safety hazards which may have caused or contributed to the incident/occurrence/occurrence, and take appropriate corrective measures if necessary.
3. The supervisor should fill out the Incident/Occurrence Report form immediately, including names of any employees who may have witnessed the incident, and ensure it is completed at the University Health Service (UHS) or Emergency Unit (EU) where the injured employee is seen, as the case may require. Then, the supervisor should send a copy of the completed form to EHSRM, as soon as practicable, but not later than 24 hours.
4. Within three days as of the date of occurrence of the incident/occurrence/occurrence, a declaration shall be filed with the relevant labor arbitration board indicating (i) the name, domicile, salary, and nationality of the injured employee, (ii) the name and domicile of the employer, (iii) the place of the incident/occurrence, and (iv) the type, nature, and circumstances of the injury. This declaration shall be accompanied by a medical report on the condition of the injured employee, the predictable sequelae, and the date at which a final report may be expected. EHSRM shall ensure that said declaration is submitted in due time.

### **Section 4 - Medical Attention**

1. Non-emergency medical attention should be provided at the University Health Service (UHS).
2. Emergency medical attention should be provided at the Emergency Unit at AUBMC.
3. Injured employees should, unless the treating physician directs otherwise, resume their work after receiving medical attention.
4. Injured employees resuming their work should submit a written medical clearance to their supervisors who, in turn, should forward a copy of the clearance to EHSRM.
5. The physician should, upon filling out the relevant section of the Incident Occurrence Report Form, state the injured employee's capacity or incapacity for work and specify a date for a second visit. The physician may specify alternative duties or reduced hours of work.
6. If, after returning to work, employees require further medical treatment or have any disability resulting from the work-related injury, they should advise their supervisors and

undergo an examination by a UHS physician. If the physician's report confirms that further treatment is required or that the employees have suffered certain disabilities as a result of the work-related injury the physician will inform the UHS director. The latter will then review the case with the help of other specialist physicians, as may be needed, and determine:

- a. The nature of the disability.
- b. If there is a total or partial disability.
- c. Whether the disability in question is permanent or temporary.

The report from the UHS director or designated UHS occupational physician shall be sent to the chair of the Worker's Compensation Committee (WCC) and to EHSRM.

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### **Section 5 - Financial Coverage**

1. Charges for immediate treatment following the occurrence of the incident/occurrence will be paid for by the department concerned.
2. Future medical care/admissions to the hospital related to the accident must be referred to the director of the UHS (Infirmary) for evaluation.
3. Disability benefits and case management will be calculated and recommended by EHSRM. The final settlement amount will be decided by the WCC and charged to the department.

### **Section 6 - Workers' Compensation Committee**

Employees' compensation regarding disability will be decided by a committee composed of:

1. Vice president for human resources (chair).
2. Comptroller.
3. Either director of Human Resources (Campus or AUBMC).
4. Director of EHSRM, or university risk manager.
5. Expert physician (by invitation when needed).
6. Treating physician (by invitation when needed).
7. Director of UHS (by invitation when needed).
8. University counsel (by invitation when needed).

### **Section 7 - Employee Compensation Procedure**

EHSRM will review each case and will consult with the appropriate occupational safety personnel, physicians who were involved in the case or produced reports related to the accident, as well as other expert physician(s) specialized in assessing work-related

disabilities. A summary of such re-evaluations will be forwarded to UHS to be kept in the individual's file.

If the disability is permanent (partial or total), EHSRM will recommend various alternatives to the WCC based on the report of the expert physician specialized in assessing work-related disabilities. These alternatives may include termination of employment, final settlement and compensation, alternative duties and rehabilitation of employee, or other forms of case management as approved by the WCC.

A [Receipt and Discharge](#) form will be prepared by EHSRM and signed by the injured employee when settlement is finalized.

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# APPENDIX I INCIDENT REPORT

(To download this form in a PDF fillable format, [click here](#))

American University of Beirut  
Incident/Occurrence Report

No. ....

**I. To be completed by Supervisor**

<b>Name of Person Involved</b>	<b>Position</b>	<b>Dept</b>	<b>Age</b>	<b>Gender</b>
<b>Date of Incident</b>	<b>Time</b>	<b>Location</b>		

**Occupation/status**

<input type="checkbox"/> Staff ID#.....	<input type="checkbox"/> Faculty	<input type="checkbox"/> House Staff	<input type="checkbox"/> Casual	<input type="checkbox"/> Student	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient & ER	<input type="checkbox"/> Visitor	<input type="checkbox"/> Other
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**Category of Incident**

<input type="checkbox"/> Needle Pricks	<input type="checkbox"/> Physical Trauma	<input type="checkbox"/> Spills	<input type="checkbox"/> Fires	<input type="checkbox"/> Near miss	<input type="checkbox"/> Treatment problem/delay	<input type="checkbox"/> Breach of confidentiality	<input type="checkbox"/> Breach in scope of practice
<input type="checkbox"/> Back Injury	<input type="checkbox"/> Equipment	<input type="checkbox"/> Chemical/Biological/Radioactive Exposure	<input type="checkbox"/> Floods	<input type="checkbox"/> Sentinel event	<input type="checkbox"/> Treatment error	<input type="checkbox"/> Breach of safety/Security	<input type="checkbox"/> Documentation error
<input type="checkbox"/> Bodily Injury	<input type="checkbox"/> Laceration	<input type="checkbox"/> Physical/verbal abuse	<input type="checkbox"/> Property damage/loss	<input type="checkbox"/> Fall	<input type="checkbox"/> Neglect	<input type="checkbox"/> Breach of policies	<input type="checkbox"/> Other (specify) .....

Complete description of incident and action(s) taken (include any objects, tools, chemicals, potential source of infection involved, etc.) \*

Corrective measures to prevent similar occurrences \*

**In Case of Personal Injury**

Cause of Injury		Agent of Injury	
<input type="checkbox"/> Caught Between	<input type="checkbox"/> Inhalation/ Ingestion/ Absorption	<input type="checkbox"/> Boilers/ Incinerator/ Steam pipes	<input type="checkbox"/> Needles
<input type="checkbox"/> Chemical/Biological Splash	<input type="checkbox"/> Struck Against	<input type="checkbox"/> Chemicals	<input type="checkbox"/> Radiation
<input type="checkbox"/> Contact With Electric Current	<input type="checkbox"/> Struck By	<input type="checkbox"/> Electric apparatus	<input type="checkbox"/> Stairs
<input type="checkbox"/> Extreme Temperature	<input type="checkbox"/> Slips/trips/falls	<input type="checkbox"/> Hand tool	<input type="checkbox"/> Surfaces
<input type="checkbox"/> Improper Handling	<input type="checkbox"/> Sharp Object	<input type="checkbox"/> Ladders	<input type="checkbox"/> Vehicle
<input type="checkbox"/> Equipment Failure	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Machine	<input type="checkbox"/> Other (specify)

<b>Completed by</b>	<b>Signature</b>	<b>Statement of involved person or person completing the report</b>
<b>Witnessed By</b>	<b>Signature</b>	
<b>Date</b>	<b>Name &amp; Signature of Dept Head/Supervisor</b>	

**II. In case of INJURY to be completed by Attending Physician**

Nature of injury and body part(s) affected: .....

Extent of Injury		Medical Intervention
<input type="checkbox"/> No injury	No effect	Was the individual involved suffering from pre-existing disease or disability before the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Minor	e.g. Scrape/bruise	<input type="checkbox"/> Diagnostic procedure: .....
<input type="checkbox"/> Moderate	e.g. x-ray/laceration	<input type="checkbox"/> Treatment (Medical/Surgical): .....
<input type="checkbox"/> Major	e.g. Fracture/head injury	<input type="checkbox"/> No treatment
<input type="checkbox"/> Catastrophic	e.g. Disability/death	Will the incident result in a permanent defect or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> No Sick Leave		<input type="checkbox"/> Sick leave ..... Days

Additional comments by Attending Physician \*

Name & Signature of Attending Physician ..... Date .....

I authorize the physician to release this report or any part of its content for administrative purposes  
 لقد تم شرح محتويات هذا التقرير و إني أؤكد الطبيب إبراز هذا التقرير أو أي جزء منه إذا اقتضت الحاجات الإدارية

Signature of the Injured .....

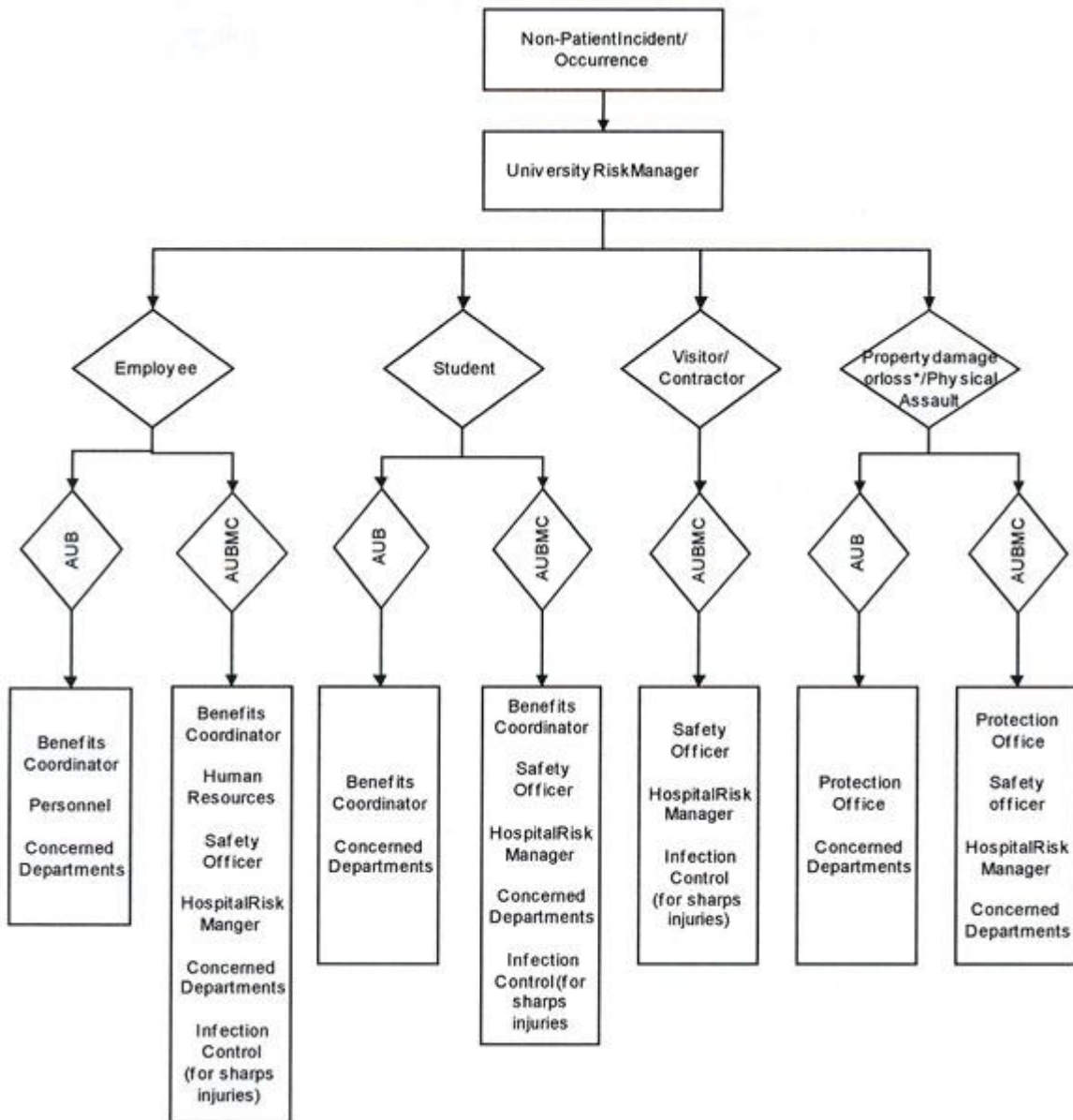
\* Use back or additional sheet if needed

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## APPENDIX II

### NON-PATIENT RELATED INCIDENT/OCCURRENCE FLOW CHART

(To download this appendix in Word format, [click here](#))



**\*Theft incidents have a specific policy and form.**

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**APPENDIX III  
RECEIPT, RELEASE, AND DISCHARGE**

**(To download this form in Word format, [click here](#))**

I, \_\_\_\_\_ (name), do hereby acknowledge receipt of US Dollars \_\_\_\_\_ (\$ \_\_\_\_\_) in full settlement and satisfaction of all claims, demands, damages, and causes of actions whatsoever I have or may have against the American University of Beirut in respect of any and all injuries or injurious results, direct or indirect, arising out from or by reason of the accident sustained by me on \_\_\_\_\_(date) on the premises, and while in the employ of the American University of Beirut.

Now, therefore, I do hereby release and discharge the American University of Beirut, its trustees, officers, and directors from any and all claims, damages, demands, liabilities whatsoever, or causes of action which I may have or may ever have in connection with, or arising out of, or on account of, any and all known and unknown, foreseen and unforeseen, bodily and personal injuries and the consequences thereof, resulting or growing out from the aforesaid accident.

I further state that I have carefully read the foregoing and know the contents thereof, and sign it as my own free act.

In witness whereof, I have signed this full, final, and irrevocable receipt, release, and discharge this \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

Signed: \_\_\_\_\_

Witness:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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