Employee Accident Report

EMPLOYEE INFORMATION

❑ Male ❑ Female

Name | EMP ID# | Home Phone

Home Address | Work Address

❑ Full-time ❑ Part-time

Years: Months:

Date of Birth | Age | Date Employed | Time in present position

Department | Shop | Job title

ACCIDENT INFORMATION

Date of Accident _____ Time of accident: ❑ am ❑ pm Time shift began: ❑ am ❑ pm

Building Location of Accident | Exact location of accident (i.e. room #, dock, lab)

What was the employee doing when the accident occurred? Describe the activity as well as the tools, equipment, or material the employee was using. Examples: "climbing a ladder while carrying roofing materials", "daily computer data entry"

What happened? Describe how the injury occurred. Examples: "when ladder slipped on wet floor, worker fell 20 feet", "worker was sprayed with chlorine when gasket broke during replacement", "worker developed soreness in wrist over time"

What was the injury or illness? Describe the part of the body that was affected and how it was affected. Example: "strained lower back"

What object or substance directly harmed the employee? Examples: "concrete floor", "chlorine"

Witnesses _____ Was this part of the normal job duty? ❑ yes ❑ no

Report prepared by (if different from the injured employee) _____ Phone _____

I understand that it is my right to apply for Workers' Compensation benefits and that I have two years from the date of this accident to do so. I also authorize the release of medical information regarding this accident to the university's Workers' Compensation claim administrators.

Employee signature _____ Date _____

SUPERVISOR/CHARGE PERSON INFORMATION

Supervisor Name _____ Supervisor Phone _____

This accident was reported to me on Date: Time: Cost Center/Dept # _____

Further investigation required? ❑ yes ❑ no Supervisor Signature _____ Date _____

HEALTH CARE PROVIDER

Treated by: ❑ Employee Health Services ❑ OSU Emergency Department ❑ Med Ohio East ❑ Med Ohio West

Other Facility Name/Address _____ Date Treated _____

Diagnosis/Assessment _____

Re-aggravation of previous injury? ❑ yes ❑ no Previous Injury Date _____

Medical Provider Printed Name _____ Medical Provider Signature _____

ADMINISTRATION

Copies Sent to: ❑ Employee ❑ OSHA LOG Coordinator ❑ OSU Integrated Disability ❑ Env. Health & Safety ❑ Supervisor

EMPLOYEE SHOULD TAKE THIS FORM AND SEEK TREATMENT FROM OSU EMPLOYEE HEALTH, 2A University Hospitals Clinic, 456 West Tenth Avenue, WITHIN 72 HOURS OF REPORTING THE ACCIDENT. Regional campus employees should be sent to local health care provider. **Return completed form to Employee Health** (FAX 614-293-8018).

Instructions for Completing the OSU Employee Accident Report

The Employee Accident Report must be completed for every work-related accident (Hospital employees should refer to the Employee Health page on Webster). This report will:

- Assist employees in obtaining immediate medical treatment
- Inform the supervisor/charge person of the accident
- Serve as a record for follow-up and future prevention efforts.

EMPLOYEE RESPONSIBILITIES:

1. Immediately notify supervisor/designated charge person of work-related accident.
2. Complete the "Employee" section of the form including signature and date.
3. Seek medical treatment if necessary.

SUPERVISOR/CHARGE PERSON RESPONSIBLITIES:

1. Complete "Supervisor/Charge Person" section of form including signature and date.
2. If the employee needs or desires medical treatment, arrange for appropriate medical care.
3. If the employee does not need/desire medical treatment, make a copy of this report for your records and send the original to OSU Employee Health. If medical treatment is needed at a later date as a result of this accident, refer to Employee Health.

MEDICAL TREATMENT:

OSU employees are entitled to treatment at OSU Employee Health. There is no charge to the employee for this treatment.

OSU Employee Health
2A University Hospitals Clinic, 456 West Tenth Avenue
Columbus, OH 43210
Phone: (614) 293-8146 FAX: (614) 293-8018
Hours (excluding holidays): Monday - Friday, 7:30 a.m. to 4 p.m.

If the employee needs immediate medical treatment and Employee Health is not open, go to the OSU Emergency Department, MedOhio West (88 North Wilson Road), or MedOhio East (OSU East Hospital) for immediate treatment and referrals for follow-up care. Regional campus employees should be sent to a local health care provider.

For Blood And Body Fluid Exposures:

Employee should report blood and body fluid exposures immediately to supervisor. (Hospital employees should refer to Blood and Body Fluid Exposure Protocol for instructions). All others should call OSU Employee Health at 614-293-8146 for instructions. A Blood and Body Fluid Report will also need to be completed.

WORKERS' COMPENSATION:

It is the employee's right to apply for Workers' Compensation benefits up to two years from the date of the accident. For more information regarding Workers' Compensation, Hospital employees may call (614) 293-3571. All other employees may contact Integrated Disability at (614) 292-3439, or 1-800-678-6413.