EMPLOYEE ACCIDENT REPORT

EMPLOYEE INFORMATION

Employee Name:_______________________________________ Social Security Number: _______________________

Home Address: ____ Telephone Number: _________________________

City: ______________________________________ State: _______ Zip: ___________ County: ________________

Gender (M/F): ________________ Date of Birth: ____________________ Age: _________

Job Title: _________________________________ Department: ______________________ Job Status (FT/PT): _____

ACCIDENT DETAILS

IT IS REQUIRED THAT FUTURE INSTANCES OF LOST WORK TIME RELATED TO THIS INCIDENT OR ILLNESS BE PROMPTLY REPORTED TO HUMAN RESOURCES BY THE EMPLOYEE

Location Where Accident Occurred (Department):____

Date and Time of Accident: __________________________________ Time Shift Started: _________________________

Name of Witnesses & Department: ____

Accident reported to:______________________________________ Date and Time Reported: ______________________

Specific Body Part(s) Affected: (Front, back, left, right, upper, etc): ____________________________________

Describe how the injury/illness occurred in detail (including what you were doing just before the accident occurred. What happened? What object or substance directly harmed you?

____

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____

First Aid/Medical Treatment Received:

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** ATTENTION: This form contain personal information relating to the individual and must be treated as Confidential information. This information should be used for Occupational Safety and Health Purposes only.

(9/2016)

Facility where treatment was sought: ____

Was this a fatal injury? (Y/N) __________________ If Yes, Date and Time: ______________________________

Have you had Prior Claims or Treatment Related to the Same Body Part? (Y/N): ___________________________

IF MACHINERY WAS INVOLVED IN THIS ACCIDENT, PROVIDE THE INFORAMTION REQUESTED BELOW

Manufacturer: _________________________ Type of Machine (Used for)_________________________

Manufactured Date: ______________________ Serial Number: ______________________________

Model: ____________________________ Location of Machine: ____________________________

Has this Machine Been Modified? (If Yes, when and what modifications were made.)

____

____

Was the Machine Guarded Properly? ______________ Was There A Mechanical Failure? __________________

ADDITIONAL INFORMATION

PLEASE INCLUDE WITH THIS REPORT ANY EQUIPMENT OR MAINTENANCE HISTORY, PHOTOGRAPHS, AND OTHER REPORTS OR COMMENTS RELATED TO THIS ACCIDENT/INJURY.

**Accident Report must be signed two times: one signature to the description of the incident and one to authorize the release of medical information.*

I certify by my signature that the information on this accident/injury report is true and complete to the best of my knowledge.

Employee Signature:____ Date: _______________

Supervisor Signature: ____ Date: _______________

As provided by Section 4123.850(c) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my Workers' Compensation claim to the Industrial Commission of Ohio. The Ohio Bureau of Workers' Compensation, the employer and its authorized representative. As such medical information, records and reports may possibly pertain to a condition either allowed or alleged in my claim, or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Workers' Compensation claim. A copy shall be as good as the original.

Employee Signature: ____Date:___________________