EMPLOYEE ACCIDENT REPORT

Read These Instructions Before Proceeding

The Employee Accident Report must be completed for every work-related accident or illness. (Medical complex personnel refer to Employee Health Web Page on the intranet.) This report will:

1. Assist employees in obtaining immediate medical treatment
2. Inform supervisor/charge person of accident
3. Be recorded for follow-up and future prevention

Below are guidelines for completing this form (**please print neatly in ink**).

Employee Responsibilities:

1. Immediately notify supervisor/designated charge person of work-related accident or illness.
2. Fully complete "Employee Information" and "Accident Information" sections, sign, and date the report.
3. Give form to supervisor/charge person for signature.
4. Seek medical treatment if necessary (see "Medical Treatment" section below).

Supervisor/Charge Person Responsibilities:

1. Complete "Supervisor/Charge Person" section. Sign and date the report. If employee needs or desires medical treatment, arrange for appropriate medical care (see "Medical Treatment" section below).
2. If employee does not need or desire medical treatment, make a copy of this report for your records and send the original to Employee Health (address is listed below). If medical treatment is needed at a later date as a result of this accident, refer employee to Employee Health Services.

Medical Treatment

Columbus campus employees should seek treatment for work related injuries and/or illness at:

OSU Employee Health Services
Phone: (614) 293-8146
Fax: (614) 293-8018
2100 Cramblett Hall (2A University Hospital Clinic Building)
456 W. 10th Ave.
Hours: Monday–Friday 7:30 a.m. to 4 p.m.

(There is no cost for medical treatment of employee accidents or injuries at Employee Health.)

If Employee Health Services is closed or unavailable, seek treatment at:

OSU Occupational Medicine East
(behind OSU East Hospital)
Phone: (614) 257-3559

OSU Occupational Medicine West
56 N. Wilson Road
Phone: (614) 293-3500

Hours: Monday to Friday 8 a.m. to 6 p.m. (Walk-ins welcome.)

After normal business hours or on weekends, seek emergency treatment, if necessary, at the OSU Medical Center Emergency Department or University Hospital East Emergency Department. (Hospital employees should report to Employee Health the next day.) For non-emergencies, seek treatment at Employee Health Services during normal business hours.

Regional campus employees should seek treatment at the designated local health provider.

For blood and body fluid exposures: Employees should report blood and body fluid exposures immediately to their supervisor. Medical complex personnel should refer to Blood and Body Fluid Exposure Protocol for instructions. All others should call OSU Employee Health at (614) 293-8146 for instructions.

Submit this report to: OSU Employee Health Services
University Hospitals Clinic
2A Cramblett Hall
456 W. 10th Ave.
Fax: (614) 293-8018

EMPLOYEE ACCIDENT REPORT

Section I: EMPLOYEE INFORMATION

click here to clear form

Name:_____ SSN: _____ Employee ID: _____
Home Address: _____ City: _____ Zip Code: _____
Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ Home Phone #: _____
Job Title: _____ Department: _____ Shop: _____
☐ Full Time ☐ Part Time Work Phone #: _____ Work Address: _____
Supervisor's Name (printed): _____ Supervisor's Phone #: _____
Supervisor's Address (Room no. and building): _____

Section II: ACCIDENT INFORMATION

Accident Date: _____ Time: _____ ☐ a.m. ☐ p.m. Time Shift Began: _____ ☐ a.m. ☐ p.m.
Location of Accident (Room no. and building): _____ Room Use (Lab, Shop, etc.): _____
What was being done before the accident occurred? _____
What happened? _____

_____

_____

Was this part of normal job duty? ☐ Yes ☐ No Body part(s) affected or injured: _____
Type of injury or illness: _____ What object or substance directly harmed the employee? _____
Witnesses (Name and Phone #): _____
Report prepared by (if different from the injured employee): _____ Phone #: _____
If you have been exposed to human blood or body fluids, refer to Medical Center Blood and Body Fluid Exposure protocol. Call Employee Health at (614) 293-8146 for instructions. (See Medical Treatment section on instructions page.) Hospital Medical Record # of source patient: _____

Section III: EMPLOYEE AUTHORIZATION

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. For more information regarding workers compensation, University Medical Center, University Hospitals East, and James Hospitals employees, call (614) 293-4107. Employees in other departments can call (614) 292-3439. I also authorize release of medical information regarding this accident to OSU BWC claim administrators.

Did the employee seek MEDICAL TREATMENT? ☐ YES ☐ NO If YES, where? _____

EMPLOYEE SIGNATURE: _____ DATE: _____

Send Columbus campus employee for treatment with this form to: Employee Health Services, 2100 Cramblett Hall (University Hospitals Clinic), 456 W. 10th Ave., within 72 hours after accident is reported. Regional campus employees should be sent to local health care provider.

If no medical treatment is necessary or if treatment is sought somewhere other than OSU Employee Health Services (EHS), send a copy of this completed report to EHS at: Fax: (614) 293-8018 or 2100 Cramblett Hall (UHC), 456 W. 10th Ave.

Section IV: SUPERVISOR / CHARGE PERSON

This accident was reported to me on: Date: _____ Time: _____ Cost Center / Department #: _____
Is further investigation required? ☐ Yes ☐ No Supervisor/Charge Person Signature: _____

Section V: HEALTH CARE PROVIDER

Treated by Employee Health? ☐ Yes ☐ No If NO, treated by? _____
Medical Provider Printed Name: _____ Medical Provider Signature: _____
Diagnosis/Assessment: _____

_____

Body part(s) affected: _____ Date Treated: _____
Is this a reaggravation of previous injury? ☐ Yes ☐ No Date of initial injury: _____
Lost Time or Restricted Duties? _____

OSHA300 Recordable Code(s): ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8

1–Injury involving loss of consciousness
2–Injury involving restriction of work or lost time
3–Injury involves transfer to another job
4–All work-related fatalities (deaths)
5–All work-related illness
6–All work-related injuries (treatment beyond first aid)
7–Not recordable
8–Human Bloodborne Pathogen Exposure

Medical Record #: _____

Send copies to: *(date/initial when sent)*

- ☐ Injured Employee
- ☐ OSU Workers' Compensation Fax: (614) 688-8120
- ☐ Medical Center Safety Fax: (614) 292-7517
- ☐ Employee Health Services Fax: (614) 293-8018
- ☐ OSHALOG Coordinator (See List)
- ☐ Environmental Health & Safety Fax: (614) 292-6404
- ☐ Supervisor/Department

ATTENTION: This form contains information relating to employee's work-related injury and must be used in a manner that protects the confidentiality of the employee to the maximum extent possible.