OHIO UNIVERSITY

EMPLOYEE INCIDENT REPORT

IMPORTANT: In the event of a work-related injury, the injured employee should obtain first aid as needed and notify the immediate supervisor of the incident as soon as practicable.

READ THESE INSTRUCTIONS BEFORE PROCEEDING

The Employee Incident Report **MUST** be completed for every work-related incident, accident, or illness, preferably within 24 hours of the incident. (Please print neatly in ink or complete electronically.)

Employee Responsibilities:

1. Seek medical treatment if necessary.
2. Notify supervisor/designated charge person.
3. **Fully complete "Employee Information" and "Accident Information" sections. Sign and date the report.**
4. Give form to supervisor/charge person for signature, and completion of the Manager Incident Report Statement.

Supervisor/Manager/Charge Person Responsibilities:

1. If the employee needs or desires medical treatment, assist in the arrangement of appropriate care.
2. Review the report, and sign as indicated in "TO BE COMPLETED BY SUPERVISOR/CHARGE PERSON."
3. **Complete the Supervisor Section of this report (page 3).**
4. Make a copy of this report for your records and provide the original to the employee.

Immediately submit a copy of these completed forms to Enterprise Risk & Workers Compensation by either:

- Email: insurance@ohio.edu
- Fax: 740-593-0386

WORKERS' COMPENSATION RIGHTS

Employees have the right to apply for Workers' Compensation benefits. They have one year from the date of injury to do so. For more information regarding Workers' Compensation, call 740-593-1641. For additional information and resources, visit **www.ohio.edu/hr/additional-resources/workers-compensation.**

SECTION 1: EMPLOYEE INFORMATION (all fields required)

Employee Type (Check One) ☐ Classified/Bargaining ☐ Administrative ☐ Faculty ☐ Student

Employee Name: ______________________________ OU Employee #: ____________________

Home Mailing Address: ______________________________ City: __________ State: _____ Zip: _______

Home/Cell Phone: ____________________ Date of Birth: ____________________ Gender: ______

Job Title: ____________________ Department: ______________________________

Work Phone: ____________________ Date Hired: ______________________________

For property damage, please complete Section 5

OHIO UNIVERSITY

EMPLOYEE INCIDENT REPORT

SECTION 2: ACCIDENT INFORMATION COMPLETED BY EMPLOYEE (provide as much detail as possible)

Supervisor Name: ____ Supervisor Phone: ________________________

Accident/Incident Date: ___________________ Accident/Incident Time: ____________ Time Shift Began:___________

Location of accident/Incident: ____

Briefly explain the accident/incident and what was being done prior:

____

____

____

____

Witness (name and phone): ____

Medical Treatment necessary: ☐ Yes ☐ No Was this part of your normal job duty: ☐ Yes ☐ No

Did employee seek medical treatment? ☐ Yes ☐ No If yes, where? _______________________________________

Type of injury or illness: (Tell us the part of the body that was affected and how) _________________________________

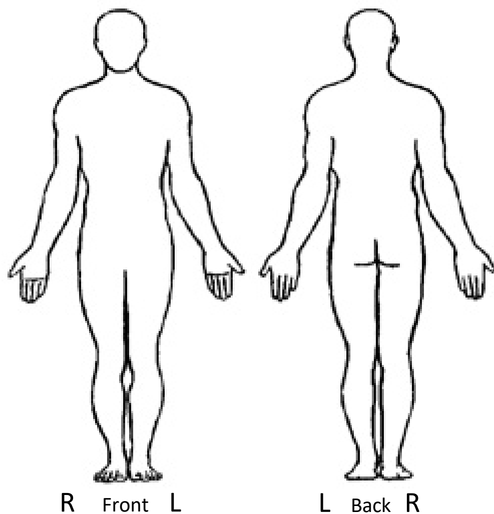
____

____

Any pre-existing injury/condition of which you are aware that could have contributed to this? ______________________

Was the employee wearing slip-resistant shoes? ☐ Yes ☐ No Was the employee using proper PPE? ☐ Yes ☐ No

Body part(s) affected/injured (circle on diagram)



	L	R
Eyes/Ears/Face		
Neck/Shoulders/Arms/Elbows		
Hips/Legs/Knees		
Ankles/Feet/Toes		
Back (Upper/Lower)		
Head		
Internal Organs		
Other: _______________________________		

SECTION 3: EMPLOYEE AUTHORIZATION

I certify the information on this form is true and authorize the release of medical information regarding this accident to OU workers' compensation claim administrators.

Employee Signature: ____ Date: _____________________

OHIO UNIVERSITY

EMPLOYEE INCIDENT REPORT

SECTION 4: TO BE COMPLETED BY SUPERVISOR/PERSON IN CHARGE

Supervisor Name: ____ Supervisor Phone: ______________________

Date accident/injury reported to supervisor: ___________________ Date investigated: _______________________

Was the employee performing regular job duties? ☐ Yes ☐ No Was a Safety Work Rule Violated? ☐ Yes ☐ No

Was the employee trained in the specific job/activity involved in this accident/injury? ☐ Yes ☐ No

(If no to any questions above, please explain in supervisor statement section)

Was required personal protective equipment used? ☐ Yes ☐ No

If no, explain: ____

Was a witness statement submitted with the Employee Incident Report? ☐ Yes ☐ No

Supervisor Statement:

____

____

____

____

____

____

____

____

____

____

____

Supervisor Signature: ____ Date: ___________________

OHIO UNIVERSITY

PROPERTY INCIDENT REPORT

SECTION 5: PROPERTY INCIDENT REPORT

Instructions:

- For university fleet vehicle accidents, complete the Ohio University Accident Reporting Kit
- If a section does not apply, indicate "N/A."
- Contact 740-597-1992 with questions.
- Submit the completed form to Enterprise Risk Management:
  - Campus mail Grosvenor Hall 345
  - fax (740) 593-0386
  - email insurance@ohio.edu

Date and time of incident: ______________________ Location of incident: __________________________________

Damaged property: ____

Incident reported by: __________________________ Work Department: ___________________________________

Supervisor: ____ Supervisor Phone: ______________________________

Name of Police Officer: _______________________________ Police report made: ☐ Yes ☐ No

City/State: ____ Police Report # _______________________________

Witnesses Name: ______________________________________ Witness Phone: ______________________________

Describe accident/incident and damage: ____

____

____

____

____

Additional Information: ____

____

____

Completed By (print): _____________________ Signature: __________________________ Date: ________________