

OHIO UNIVERSITY EMPLOYEE INCIDENT REPORT

FOR UNIVERSITY EMPLOYEE INCIDENTS: Supervisor (and/or employee) must complete form immediately after a work-related injury, illness or incident. *Employee must report any injury to their supervisor before the end of their shift.* Attach additional sheets if necessary. Supervisors must investigate the incident thoroughly and submit the form within **one working day** to: Workers Compensation at 121A HRTC, and also report by phone at 597-1994.

1. Employee (please check one) Classified Administrative Bargaining Faculty Student Employee
 Other (If "other" please describe) _____
2. Name _____ 3. Employee # _____ 4. Date of Birth _____ 5. Gender _____
6. Mailing Address _____ 7. City _____ 8. State _____ 9. Zip _____
10. Home Phone _____ 11. Campus Phone _____ 12. Dept _____
13. Bldg/Area/Shop _____ 14. Date Hired _____ 15. Job Title _____
16. Date incident occurred _____ 17. Time of Incident ___:___ AM PM
18. Time Employee Began Work ___:___ AM/PM
19. Full name and phone # of any witnesses _____

20. What was the individual doing and where just before the incident? Describe the activity, any tools, equipment, or material the individual was using/carrying. Be specific. Examples: "climbing a ladder while carrying roofing materials", "leaving Memorial Auditorium through north doors." Please state the location on campus at time of the incident.

21. What happened? How did the injury occur? Examples: "When ladder slipped on wet floor, worker fell 20 feet". Please list any unsafe conditions/acts or violation of safety rules or practices. What went wrong?

22. What was the injury or illness? Tell us the part of the body that was affected and how. Be more specific than "hurt" or "pain", or "sore". Examples: "strained lower back", "sprained left ankle".

23. What object or substance directly injured the individual? Examples: "concrete floor", "bricks on sidewalk". If this question does not apply to the incident, leave blank _____
24. Name of Health Care Provider for this incident _____ Dr. _____ Date: _____
25. Was employee performing regular job duties? ___Yes ___No
26. Was employee trained in the specific job/activity involved in this incident? ___ Yes ___ No (If No, explain)

27. What has been/will be done to prevent this type of incident (corrections, actions, repairs, training, etc.)

28. Any pre-existing injury/condition of which you're aware that could have contributed to this ___No ___Yes
29. Date injury reported to supervisor by employee _____ 30. Date Investigated _____ (If date investigated is different from date reported, why? _____)
31. Death? ___No ___Yes If yes, date: _____
32. Supervisor's Name (please print) _____ 33. Phone # _____
33. Supervisor's Email Address _____
34. Signature of injured/ill person _____ 35. Date Report Completed _____
35. Investigator's Signature _____

NOTICE: Per ORC 2913.48, a person commits workers' compensation fraud if the person: makes false or misleading statements with the purpose of securing goods or services under the Workers' Compensation Act.