

OHIO UNIVERSITY EMPLOYEE INCIDENT REPORT

FOR UNIVERSITY EMPLOYEE INCIDENTS: Supervisor (and employee) must complete form immediately after a work-related injury, illness or incident. *Employee must report any injury to their supervisor/acting 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: Human Resources and Training Center, Room #120, 169 W. Union St, by fax at (740) 593-0386, or by email jamese@ohio.edu.

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: "possible strained lower back" or "potentially 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 (Date Trained: _____) __ 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. Was the employee wearing slip-resistant shoes? No Yes 33. Using proper PPE? No Yes
34. Name of manager on duty at time of injury _____
35. Supervisor's Name (please print) _____ 36. Phone # _____
37. Supervisor's Email Address _____
38. Signature of injured/ill person _____ 39. Date Report Completed _____
40. Supervisor's Signature _____

NOTICE: Supervisor: please give a copy of this form to the employee upon completion.

Employee Incident Report Statement

Date _____

Print Name _____

Signature _____

Manager Incident Report Statement

Date _____

Supervisor to complete:

Was a Safety Work Rule violated _____

Supervisor to complete:

What Safety Work Rule was violated _____

Supervisor to complete:

Permanent employees - discipline/counseling requested ? _____
Student employee: Number of strikes applied? _____
Outcome? _____

Print Name _____

Signature _____