

The Ohio State University Employee Accident Report

EMPLOYEE INFORMATION

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 & Building): _____

ACCIDENT INFORMATION

Accident Date: _____ Time: _____ am pm Time Shift Began: _____ am pm
Location of Accident (Room # & 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 & 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 293-8146 for instructions (see medical treatment section on reverse side) Hospital Medical Record # of source person: _____

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 and James Hospitals employees, call 293-3571; Employees in other departments call 292-3439. I also authorize release of medical information regarding this accident to OSU BWC claim administrators.

EMPLOYEE SIGNATURE: _____ DATE: _____

SEND EMPLOYEE FOR TREATMENT WITH THIS FORM TO: EMPLOYEE HEALTH, 2A UNIVERSITY HOSPITALS CLINIC, 456 WEST 10TH AVENUE, WITHIN 72 HOURS AFTER ACCIDENT IS REPORTED Regional campus employees should be sent to local health care provider.

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: _____

HEALTH CARE PROVIDER

Treated by Employee Health? Yes No If No, treated by? _____

Diagnosis / Assessment: _____

Body part(s) affected: _____

Is this a re-aggravation of previous injury? Yes No Date of initial injury: _____ Lost Time or Restricted Duties? Yes No

Medical Provider Printed Name: _____ Medical Provider Signature: _____

OSHA300 Recordable Code(s): 1 2 3 4 5 6 7 8 Medical Record #: _____

Copies sent to: Employee: _____ OSHALOG Coordinator: _____ OSU Worker's Comp: _____ EH&S: _____ Supervisor: _____
Fax: 688-8120 Fax: 292-6404

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

THE OHIO STATE UNIVERSITY EMPLOYEE ACCIDENT REPORT

The Employee Accident Report must be completed for every work-related accident (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 in ink**).

EMPLOYEE RESPONSIBILITIES:

1. Immediately notify supervisor/designated charge person of work-related accident / illness.
2. Fully complete "Employee Information" and "Accident Information" sections, sign and date the report. **(PRINT USING INK)**
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 & date the report. If employee needs/desires medical treatment, arrange for appropriate medical care (see "Medical Treatment" section below). **(PRINT USING INK)**.
2. If employee does not need/desire medical treatment make a copy of this report for your records & send the original to Employee Health. If medical treatment is needed at a later date as a result of this accident, refer employee to Employee Health.

MEDICAL TREATMENT:

Seek treatment for work related injuries and/or illness at:

OSU Employee Health - Phone: (614) 293-8146; FAX: (614) 293-8018
2A University Hospital Clinic Bldg (Cramblett Hall)
456 West 10th Avenue
Hours: Monday – Friday 7:30 AM to 4:00 PM
(There is no cost for treatment at Employee Health)

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

OSU Occupational Medicine East (behind OSU east Hospital) Phone: (614)257-3559	OSU Occupational Medicine West 56 North Wilson Road Phone: (614) 274-3900
Hours: Monday to Friday 8 AM to 6 PM	

After normal business hours or on weekends, seek treatment at the OSU Emergency Department Main or University Hospital East (hospital employees should report to employee health the next day).

Regional Campus employees should be sent to the designated local health provider

For Blood and Body Fluid Exposures:

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

Submit this report to:

OSU Employee Health (fax: 614-293-8018), 2A Cramblett Hall (University Hospitals Clinic), 456 W. Tenth Ave.

OSHA300 "Recordable Code" key	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