

Report # _____ **The Ohio State University Wooster Campus Employee Accident Report**

EMPLOYEE INFORMATION (Print in Ink)

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 614-293-8146 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 614- 293-3571; Employees in other departments call 614-292-3439. I also authorize release of medical information regarding this accident to OSU BWC claim administrators.

EMPLOYEE SIGNATURE: _____ DATE: _____

SEND EMPLOYEE FOR TREATMENT TO MEDPRO GROUP WITHIN 72 HOURS AFTER ACCIDENT IS REPORTED
Regional campus employees should be sent to local health care provider. (Do Not Leave form with Medical 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 MedPro Group 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 OARDC Safety Office or EHS OSU WC OSU Employee Health OSU EH&S Supervisor / Dept:
Fax Numbers 263-3767 88-8120 Fax: 83-8018 Fax: 82-6404

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 WOOSTER CAMPUS EMPLOYEE ACCIDENT REPORT

The Employee Accident Report must be completed for every work-related accident. 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. Review employee and accident section. 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 or refuses medical treatment make a copy of this report for your records. Annotate Health Care Provider section with a statement "**Medical care refused or not required**". Send the signed original form to OARDC Human Resource Office or ATI Business Office. If medical treatment is needed at a later date as a result of this accident, refer employee to MedPro Group.

MEDICAL TREATMENT:

Wooster Campus seek treatment for work related injuries and/or illness at: Piketon and Branches

MedPro Group – phone 330-263-7270
2201 Benden Drive, Wooster, OH 44691
Hours: Monday – Friday 8:00 AM to 5:00 PM
(There is no cost for treatment at MedPro Group)

Designated Local Provider

If MedPro Group is closed or unavailable, seek treatment at:

Wooster Community Hospital Emergency Department
1761 Beall Avenue; Wooster, OH 44691

Branch & Piketon Employees
Local Emergency Room

After normal business hours or weekends/holidays, seek treatment at the Wooster Community Hospital Emergency Department.

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. For instructions call OSU Employee Health (614-293-8146).

Submit this report to:

OARDC Employees: Human Resources, Research Services; fax 330-3695*

ATI Employees: Business Office, 211 Halterman Hall; fax 330-262-7634*

***IF YOU FAX THIS REPORT, PLEASE MAIL OR DROP OFF THE ORIGINAL SIGN REPORT**

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