EMPLOYEE'S REPORT OF INCIDENT AND INJURY
PLEASE PRINT IN INK-To be completed by Employee

EMPLOYER:

Name_____ Social Sec. _____

Home Address_____ Birth Date_____

City/State/Zip_____ Sex: ☐ Male ☐ Female

Telephone: ( )_____ Alternate Phone: ( )_____

Date of injury **or** onset of symptoms_____ Time_____ ☐ am ☐ pm
Describe what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**
_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____

Did you report this incident to anyone? ☐ Yes ☐ No If not, why?_____

If yes, to whom did you report it? (Name and Title/Position)_____

When? (Date and Time)_____

What part(s) of your body was/were affected? (BE SPECIFIC- for example: right elbow, left knee, right index finger):
_____

What type of injury did you experience? (BE SPECIFIC- for example: bruise, scrape, laceration, pull):
_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: _____
_____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?_____

Where?_____

If treatment was not sought immediately, explain why: _____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury? _____

By whom or where? _____
_____

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____
_____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____

INDUSTRIAL INJURY FACT SHEET
EMPLOYER/SUPERVISOR

Employee Name: _____ **Soc. Sec.** _____

Employer: _____ **Date of Injury:** _____

Was an investigation completed concerning the circumstances of this injury? ☐ Yes ☐ No

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: ☐ Yes ☐ No

_____
_____
_____

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If yes, please describe (and attach any written documentation):

_____
_____

Has the employee missed any work previously due to similar industrial or non-industrial conditions? If so, when? ☐ Yes ☐ No _____

Has the employee submitted medical documentation for the injury? ☐ Yes ☐ No
If so, please attach.
If known, please provide us with the name, address and telephone number of the attending physician: _____
_____
_____
_____

Has the employee returned to work? ☐ Yes ☐ No

Last day worked (date)_____ Returned to work (date)_____

If not, what is the current estimated date of return? _____

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No

If no, why not? _____

_____ _____ _____
Employer's signature Title Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.

STATEMENT OF WITNESS TO ACCIDENT

EMPLOYER:

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident_____ Shift_____

Occupation_____ Department_____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name_____ Your occupation_____

Your address_____ Your telephone number ( ) _____ - _____

_____

Did you see an accident involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident?_____

_____

If you did see an accident occur: Date of accident_____ Time of accident_____ ☐am ☐pm

Describe what you saw: _____

_____

_____

_____

_____ _____ _____

Your signature Please print your name Date

State of Ohio

County of _____

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at _____, Ohio this _____ day of _____, 20_____.

(SEAL)

(signed)_____

Name (printed or typed)_____

Notary Public, State of Ohio

My Commission Expires_____(date)