ACCIDENT/INJURY REPORT FORM
Scan & Return to healthreporting@edisonohio.edu

☐ Employee FT ☐ Employee PT ☐ Employee Misc. ☐ Student
☐ Contractor ☐ Visitor ☐ Other: _____

Name: _____ Home Address: _____
Number/Street Name

Supervisor: _____ _____
City, State, Zip

Sex: M ☐ F ☐ Phone Number _____ Form Completed by: _____

Date of Accident/Injury: _____ Time accident/Injury occurred: _____A.M. _____P.M.

Place of Accident/Injury: Piqua Campus ☐ Eaton Campus ☐ Greenville Campus ☐ Troy Campus ☐

Off Site Location ☐ _____
Name/Address

Type of Injury

☐ Abrasion ☐ Poisoning
☐ Bite ☐ Puncture
☐ Burn ☐ Scalds
☐ Contusion (Bruise) ☐ Scratches
☐ Concussion ☐ Shock, Electrical
☐ Cut ☐ Sprain
☐ Dislocation/Fracture
☐ Other (Specify) _____

Body Part Affected

☐ Extremity , Lower ☐ Left Side
☐ Extremity , Upper ☐ Right Side
☐ Head
☐ Torso

Blood**

Was blood or any other body fluids present?
☐ Yes ☐ No

If yes, was anyone exposed to blood or any other body fluids?
☐ Yes** ☐ No

** If an employee was exposed to another person's blood or bodily fluids, please refer to exposure procedures at ????@edisonohio.edu

Cause of Injury

☐ Animal/Insect
☐ Assault
☐ Chemicals
☐ Collision: Fixed Object
☐ Contact: Electric Current
☐ Cumulative (All Other)
☐ Dust/Gasses/Fumes/Vapors
☐ Explosion
☐ Fall/Slip: Level Ground, Ladder, From Liquid
☐ Fall/Slip: Same Level, Ice/Snow, Miscellaneous
☐ Fire/Flame
☐ Hot Objects
☐ Medical Procedure
☐ Motor Vehicle
☐ Object Being Lifted
☐ Slipped But Did Not Fall
☐ Strain: Push/Pull, Repetitive Motion, Miscellaneous
☐ Strain: Lifting, Using Tool, Reaching, Hold/Carry
☐ Stepping on Sharp Object
☐ Struck: Falling Object, Fellow Worker, Tools
☐ Struck: Vehicle, Object Lifted, Miscellaneous
☐ Welding Operations
☐ Other (Specify) _____

Please Provide a Brief Description of the Accident: *(What, where, how)*

☐ Additional Information Attached

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Treatment Information	**Initial Treatment:** ✓ **All That Apply** ☐ No Medical Treatment ☐ Minor by Employee ☐ Minor by Employer ☐ Occupational Health ☐ Emergency Care (Hospital) ☐ Hospitalized (≥24 Hours) ☐ Transport by Ambulance	Physician Name (Last, First, MI: _____ Physician Street Address: _____ Physician City, State, Zip: _____ Hospital: _____ Hospital Street Address: _____ Hospital City, State, Zip: _____ ☐ Returned to work with no restrictions ☐ Returned to work with restrictions ☐ Returned to work with no restrictions ☐ Off work

Witnesses	**Names**	**Phone Number**	**Address**
	☐ Additional Information Attached		

Yes	**No**		**Explain**
		Edison State Property Involved?	
		Damage to Equipment Caused by Accident?	
		Did Inadequate Guarding Contribute to Accident?	
		Was a Defective Tool or Equipment at Fault?	
		Was Required PPE Being Used at Time of Accident?	
		Was Instructor In Room at Time of Accident?	

For DPS Use Only
☐ DPS Responded Unit # _____ ☐ DPS Report Filed Date: _____ Case # _____
Is Blood & Body Fluid Exposure Report Form required? ☐ Yes ☐ No