

ACCIDENT/INJURY REPORT FORM

Scan & Return to healthreporting@edisonohio.edu

<input type="checkbox"/> Employee FT	<input type="checkbox"/> Employee PT	<input type="checkbox"/> Employee Misc.	<input type="checkbox"/> Student
<input type="checkbox"/> Contractor	<input type="checkbox"/> Visitor	<input type="checkbox"/> Other: _____	
Name: _____		Home Address: _____	
		Number/Street Name	
Supervisor: _____		_____	
		City, State, Zip	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Phone Number _____	
		Form Completed by: _____	
Date of Accident/Injury: _____		Time accident/Injury occurred: _____ A.M. _____ P.M.	
Place of Accident/Injury: Piqua Campus <input type="checkbox"/> Eaton Campus <input type="checkbox"/> Greenville Campus <input type="checkbox"/> Troy Campus <input type="checkbox"/>			
Off Site Location <input type="checkbox"/> _____			
Name/Address			
Type of Injury	<input type="checkbox"/> Abrasion <input type="checkbox"/> Bite <input type="checkbox"/> Burn <input type="checkbox"/> Contusion (Bruise) <input type="checkbox"/> Concussion <input type="checkbox"/> Cut <input type="checkbox"/> Dislocation/Fracture <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Poisoning <input type="checkbox"/> Puncture <input type="checkbox"/> Scalds <input type="checkbox"/> Scratches <input type="checkbox"/> Shock, Electrical <input type="checkbox"/> Sprain	Cause of Injury
Body Part Affected	<input type="checkbox"/> Extremity , Lower <input type="checkbox"/> Extremity , Upper <input type="checkbox"/> Head <input type="checkbox"/> Torso	<input type="checkbox"/> Left Side <input type="checkbox"/> Right Side	<input type="checkbox"/> Animal/Insect <input type="checkbox"/> Assault <input type="checkbox"/> Chemicals <input type="checkbox"/> Collision: Fixed Object <input type="checkbox"/> Contact: Electric Current <input type="checkbox"/> Cumulative (All Other) <input type="checkbox"/> Dust/Gasses/Fumes/Vapors <input type="checkbox"/> Explosion <input type="checkbox"/> Fall/Slip: Level Ground, Ladder, From Liquid <input type="checkbox"/> Fall/Slip: Same Level, Ice/Snow, Miscellaneous <input type="checkbox"/> Fire/Flame <input type="checkbox"/> Hot Objects <input type="checkbox"/> Medical Procedure <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Object Being Lifted <input type="checkbox"/> Slipped But Did Not Fall <input type="checkbox"/> Strain: Push/Pull, Repetitive Motion, Miscellaneous <input type="checkbox"/> Strain: Lifting, Using Tool, Reaching, Hold/Carry <input type="checkbox"/> Stepping on Sharp Object <input type="checkbox"/> Struck: Falling Object, Fellow Worker, Tools <input type="checkbox"/> Struck: Vehicle, Object Lifted, Miscellaneous <input type="checkbox"/> Welding Operations <input type="checkbox"/> Other (Specify) _____
Blood**	Was blood or any other body fluids present? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was anyone exposed to blood or any other body fluids? <input type="checkbox"/> Yes** <input type="checkbox"/> No ** If an employee was exposed to another person's blood or bodily fluids, please refer to exposure procedures at healthreporting@edisonohio.edu		
Please Provide a Brief Description of the Accident: <i>(What, where, how)</i>			
<input type="checkbox"/> Additional Information Attached			

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Treatment Information	Initial Treatment: <input checked="" type="checkbox"/> All That Apply <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor by Employee <input type="checkbox"/> Minor by Employer <input type="checkbox"/> Occupational Health <input type="checkbox"/> Emergency Care (Hospital) <input type="checkbox"/> Hospitalized (≥24 Hours) <input type="checkbox"/> Transport by Ambulance	Physician Name (Last, First, MI: _____ Physician Street Address: _____ Physician City, State, Zip: _____ Hospital: _____ Hospital Street Address: _____ Hospital City, State, Zip: _____ <input type="checkbox"/> Returned to work with no restrictions <input type="checkbox"/> Returned to work with restrictions <input type="checkbox"/> Returned to work with no restrictions <input type="checkbox"/> Off work		
	Witnesses	Names	Phone Number	Address
	<input type="checkbox"/> 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

<input type="checkbox"/> DPS Responded Unit # _____	<input type="checkbox"/> DPS Report Filed Date: _____	Case # _____
Is Blood & Body Fluid Exposure Report Form required?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	