



Part I Injury Report (to be completed as soon as possible following an accident and must be provided to the department supervisor within 24 hours of the accident.) (Email a copy to Timothy Werdmann within 48 hrs)

Employee Name, Date of Incident, Time of Incident, Time employee began work, Place of incident (Exact Work Site), Work Dept./Div, Date Hired, Date of Birth, Age, Sex (M/F), Employee Social Security Number, Job Classification, Employee Home Address, City, State, Zip, Person Completing Form, Date Reported To Supervisor

Was Incident Reported Immediately? [ ] Yes [ ] No To Whom

If no, explain

Detailed description of the accident (Sequence of events directly supporting or caused the incident) Continue on page 2 if needed

Benefit application release of information - I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim.

Employee's Signature, Date Signed

Nature of Injury (Parts of Body Affected) Re-injury of existing condition? [ ] Yes [ ] No

Body Part: [ ] head, [ ] hand/finger, [ ] mid or lower back, [ ] not applicable, [ ] Right, [ ] Left, [ ] eye, [ ] chest/ abdomen, [ ] leg / ankle, [ ] other, [ ] arm, [ ] neck, [ ] foot / toes

Type of Incident: [ ] struck by, [ ] lifting, [ ] vehicle, [ ] struck against, [ ] caught in, under or between, [ ] cumulative trauma, [ ] overexertion, [ ] contact with electricity, [ ] property damage only, [ ] slip, trip or fall (same level), [ ] exposure to hot temperatures, [ ] bite / sting, [ ] slip, trip or fall (elevation), [ ] chemical exposure, [ ] other



- Type of Injury
- laceration
  - burn(heat)
  - respiratory
  - contusion (bruise bump)
  - burn (chemical)
  - illness
  - electric shock
  - muscle strain or sprain
  - dog bite
  - fracture
  - cardiac
  - insect sting bite
  - inflammation
  - amputation
  - non-work related
  - not applicable
  - other

**Part II Incident Confirmation** (to be completed by supervisor)

Where was treatment given?  Worksite  Off-site  On and Off-site

Worksite first aid provided by

Describe worksite first aid treatment

Medical Provider's name if treated off-site

Describe off-site treatment (Please attach care provider notes and send with the report)

Medical Provider's Address

Was employee treated in an emergency room?  Yes  No

Was employee hospitalized overnight as an in-patient?  Yes  No

How was the incident verified? If possible, please attach statements.

Employee Statement Only  Witness Name of Witnesses

Can employee be reassigned to restricted duty?  Yes  No If yes, date of first day of restricted duty

Will the injury result in Lost Workdays?  Yes  No If yes, date of first day of lost work

Supervisor Signature  Date Signed



Additional description of the accident (Sequence of events that directly supported or caused the incident)

**Part III Employer Information**

Employer Policy Number: 30905102-0    Employer Federal ID Number: 31-6000 142    Manual Number: 9431