

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

EMPLOYER:

[Redacted Employer Information]

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:

[Redacted box]

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)