MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee * OSHA 301 Info in BOLD

Name: _____ Social Sec. No. XXX-XX-_____ (Last 4-digits only)

Home Address: _____ **Date of Birth:** _____ **Sex:** ☐ Male ☐ Female

City/State/Zip: _____ Telephone: ( ) _____

Title/Position: _____ Department: _____

Accident Location: _____

Date of Injury or onset of symptoms: _____ Time: _____ ☐ am ☐ pm

Described 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:

Were you performing regular duties at the time of accident? ☐ Yes ☐ No

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

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

If yes, to whom did you report it?:_____ Title/Position:_____ When: _____

What time did you start work today? _____ am/pm. **What time was the injury?**_____am/pm ☐ Unknown

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: _____

_____

Provided by: _____

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 Law, 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): _____

MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: _____ **Date of Injury:** _____ **OSHA Log #**_____

OSHA 301 Info in Bold

Was the employee killed as a result of the accident? If yes, indicate date of death:_____

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? ☐ **Yes** ☐ **No**
If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? ☐ **Yes** ☐ **No**
If so, please describe:

_____

_____

Has the employee submitted medical documentation for the injury? If so, please attach. ☐ **Yes** ☐ **No**

Was the employee treated in an emergency room or similar? ☐ **Yes** ☐ **No**

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

If known, please provide us with the name, address and telephone number of attending physician and/or hospital:

Physician:_____ Facility:_____

_____ _____

_____ _____

Has the employee returned to work? ☐ **Yes** ☐ **No**

Last Day worked _____ Returned to work _____

Does the employee have restrictions to duty? ☐ **Yes** ☐ **No** Applicable dates:_____

Is the employee performing their full duties? ☐ **Yes** ☐ **No**

Was the employee given a prescription by the physician? ☐ **Yes** ☐ **No**

Employee Date of hire: _____

Have the conditions that caused the accident been controlled? ☐ **Yes** ☐ **No**

Describe action taken to prevent the accident in the future:_____

_____

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

If no, why? _____

Completed by:

_____ _____
Supervisor Signature/Title/Phone Date

_____ _____
Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.

MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

STATEMENT OF WITNESS TO ACCIDENT

I. INCIDENT INDENTIFICATION INFORMATION

Name of employee alleging incident: _____ Shift: _____

Title/Position: _____ 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 Title/Position: _____

Your Address: _____ Your Phone 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**

MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

EMPLOYEE INCIDENT / ACCIDENT REPORT

BACK INJURY REPORT

*** To Be Completed When a Back Injury is Reported by the Injured Employee***

Name: _____ Social Sec. No. XXX-XX-_____ (Last 4-digits only)

Home Address: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

City/State/Zip: _____ Telephone: ( ) _____

Title/Position: _____ Department: _____

What part of your back hurts now? _____

When did you first notice this back pain? Date: _____ Time: _____ ☐ am ☐ pm

What were you doing at that time (explain in detail)? _____

_____

_____

If you were lifting an object, what was it and how heavy? _____

_____

_____

What did you feel? _____

What was the length of time between the injury and your disability, if any? _____

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

Did you report or mention this injury to anyone? ☐ Yes ☐ No If yes, who? _____ When? _____

Did you ever have a back injury before? ☐ Yes ☐ No If yes, when? _____

What part of your back? _____

Were you ever treated by a doctor? ☐ Yes ☐ No If so, when? _____

Has it given you further trouble since then? _____

Have you ever received or filed for compensation because of a back injury? ☐ Yes ☐ No

Any other injury? ☐ Yes ☐ No If yes, list Bureau of Workers' Compensation claim number(s): _____

_____

Medical Release **- Under current Workers' Compensation Law, 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):** _____