

**READ THESE INSTRUCTIONS BEFORE PROCEEDING**

The Employee Accident Report must be completed for every work-related accident or illness. (Medical complex personnel refer to University Health Services' Web Page on the intranet.) This report will:

1. Assist employees in obtaining immediate medical treatment
2. Inform supervisor/charge person of accident
3. Be recorded for follow-up and future prevention

Below are guidelines for completing this form (please print neatly in ink or complete electronically)

**Employee Responsibilities:**

1. Immediately notify supervisor/designated charge person of work-related accident or illness.
2. Fully complete "Employee Information" and "Accident Information" sections, sign and date the report.
3. Give form to supervisor/charge person for signature.
4. Seek medical treatment if necessary (see "Medical Treatment" section below).

**Supervisor/Charge Person Responsibilities:**

1. Complete "Supervisor/Charge Person" section, sign and date the report. If the employee needs or desires medical treatment, assist in the arrangement of appropriate care (see "Medical Treatment" section below).
2. Complete the "Supervisor Accident Analysis Report" (see page four of the report)
3. Make a copy of this report for your records, provide the original to the employee, and immediately submit a copy of this completed accident report to Integrated Absence Management and Vocational Services by either fax or e-mail, as indicated on page two.

**MEDICAL TREATMENT**

Send employees for treatment with this form within 72 hours after the accident is reported. To determine whether medical treatment is necessary or where to seek medical treatment, contact the 24/7 Nurseline anytime at 800-678-6269.

Columbus campus employees should seek treatment for work-related injuries and/or illness at:

OSU University Health Services  
McC Campbell Hall, 2nd floor  
1581 Dodd Drive  
Phone: 614-293-8146

**Hours: M–F, 7:30 a.m. to 4 p.m.**  
(There is no cost for medical treatment of employee accidents or injuries at University Health Services.)

After Hours Care – Martha Morehouse Medical Plaza  
2nd Floor, Suite 2400, Pavilion  
2050 Kenny Road  
Columbus, OH 43212  
Phone: 614-685-3357

**Hours: M–F, 5 p.m.–11 p.m., SAT–SUN, 10 a.m.–6 p.m.**

**For serious injuries that need emergency medical attention:**

Seek emergency treatment at Ohio State's Wexner Medical Center Emergency Department or University Hospital East Emergency Department. (Hospital employees should report to University Health Services the next day.)

Regional campus employees should seek treatment at the designated local health provider.

**For blood and body fluid exposures (BBFE):** Employees must report blood and body fluid exposures immediately to their supervisor and complete the BBFE Addendum to this report. Wexner Medical Center personnel should refer to Blood and Body Fluid Exposure Protocol for instructions. All others should call University Health Services at 614-293-8146 or 24/7 Nurseline at 800-678-6269 for instructions.

**WORKERS' COMPENSATION RIGHTS**

Employees have the right to apply for Workers' Compensation benefits. They have two years from the date of this accident to do so. For more information regarding Workers' Compensation, call 614-292-3439.

Submit this report to Integrated Absence Management and Vocational Services:

Fax: 614-688-8120 or Email: [accidentreport@osu.edu](mailto:accidentreport@osu.edu)

**SECTION 1: EMPLOYEE INFORMATION (all fields required)**

Employee's Full Name: First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_ OSU Employee ID# \_\_\_\_\_  Full Time  Part Time

Home Mailing Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Job Title \_\_\_\_\_ Department \_\_\_\_\_ Work Phone \_\_\_\_\_ Date Hired \_\_\_\_\_

Work Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Supervisor's Full Name: First \_\_\_\_\_ Last \_\_\_\_\_ Supervisor's Phone \_\_\_\_\_

**SECTION 2: ACCIDENT INFORMATION (provide as much detail as possible)**

Accident date: \_\_\_\_\_ Accident time: \_\_\_\_\_  A.M.  P.M. Time shift began: \_\_\_\_\_  A.M.  P.M.

Date of death, if applicable: \_\_\_\_\_ Location of accident (room use/building/shop): \_\_\_\_\_

Briefly explain the accident and what was being done just prior: \_\_\_\_\_

Was this part of your normal job duty?  Yes  No

What object or substance directly harmed the employee?  
\_\_\_\_\_

Type of injury or illness: \_\_\_\_\_

Witness (name and phone): \_\_\_\_\_

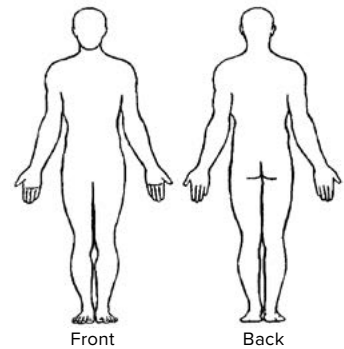
Did employee seek medical treatment?  Yes  No

If yes, where? \_\_\_\_\_

This report prepared by (name and phone, if different from injured employee):  
\_\_\_\_\_

**Body part(s) affected/injured (circle on diagram)**

- |                            |                          |                          |
|----------------------------|--------------------------|--------------------------|
|                            | L                        | R                        |
| Eyes/Ears/Face             | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck/Shoulders/Arms/Elbows | <input type="checkbox"/> | <input type="checkbox"/> |
| Hips/Legs/Knees            | <input type="checkbox"/> | <input type="checkbox"/> |
| Wrist/Hands/Fingers        | <input type="checkbox"/> | <input type="checkbox"/> |
| Ankles/Feet/Toes           | <input type="checkbox"/> | <input type="checkbox"/> |
| Back (Upper/Lower)         | <input type="checkbox"/> |                          |
| Head                       | <input type="checkbox"/> |                          |
| Internal Organs            | <input type="checkbox"/> |                          |
| Other: _____               |                          |                          |



**For blood/body fluid exposure, the Addendum (on page 3) must be fully completed.**

Hospital Medical Record# of source patient: \_\_\_\_\_

Please review the Medical Treatment information on page 1 of this form. **If no medical treatment is necessary or if treatment is sought somewhere other than University Health Services (UHS), submit a copy of this completed report to Integrated Absence Management and Vocational Services at Fax: 614-688-8120 or email: [accidentreport@osu.edu](mailto:accidentreport@osu.edu).**

**SECTION 3: EMPLOYEE AUTHORIZATION**

I understand that it is my right to apply for Workers' Compensation benefits and that I have two years from the date of this accident to do so. I also authorize release of medical information regarding this accident to OSU BWC claim administrators.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 4: TO BE COMPLETED BY SUPERVISOR/CHARGE PERSON**

This accident was reported to me on: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Cost Center/Department#: \_\_\_\_\_

Is further investigation required?  Yes  No If yes, why: \_\_\_\_\_

Signature of Supervisor/Charge Person \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 5: TO BE COMPLETED BY HEALTH CARE PROVIDER**

Treated by University Health Services?  Yes  No If no, treated by? \_\_\_\_\_

Medical provider printed name: \_\_\_\_\_ Medical provider signature: \_\_\_\_\_

Diagnosis/Assessment: \_\_\_\_\_

Body part(s) affected: \_\_\_\_\_ Date treated: \_\_\_\_\_

Reaggravation of a previous injury?  Yes  No If yes, date of initial injury: \_\_\_\_\_

Full Duty  Restricted Duty Date (if restricted, please use MEDCO-14): \_\_\_\_\_

**OSHA/PERRP 300 Classification**

Injury/Illness: (Check only 1 box)  (1) Injury - All Other  (2) Skin Disorder  (3) Respiratory Condition  (4) Poisoning  (5) Hearing Loss  (6) Illness - All Other

Severity: (check only 1 box):  Not Recordable  (J) Other Recordable Cases  (I) Restrictions or Job Transfer  (H) Days Away from Work  (G) Death

Medical Record# \_\_\_\_\_

**ATTENTION:** This form contains information relating to employee's work-related injury and must be used in a manner that protects the confidentiality of the employee to the maximum extent possible. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**Submit copies to:** (1) Integrated Absence Management and Vocational Services: Fax: 614-688-8120 or email: [accidentreport@osu.edu](mailto:accidentreport@osu.edu) (2) Supervisor/Department (3) Injured Employee

**ALL parts of this form MUST be completed with as much detail as possible.**

This form must be submitted directly to Integrated Absence Management and Vocational Services (not to supervisor).

## SECTION 1: EMPLOYEE INFORMATION

Employee's Full Name: First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_ OSU Employee ID# \_\_\_\_\_

Occupation \_\_\_\_\_ Phone Number (for reporting lab results) \_\_\_\_\_ Date of Hire \_\_\_\_\_

Date of exposure: \_\_\_\_\_ Time of exposure: \_\_\_\_\_ Number of hours on duty: \_\_\_\_\_ Pregnant:  Yes  No

## SECTION 2: BBFE INFORMATION

Specific location of exposure (room use and building): \_\_\_\_\_

Location type (patient room, laboratory, bathroom): \_\_\_\_\_

Cause of the exposure (splash, needlestick, bite): \_\_\_\_\_

Detailed account of the event (be as specific and detailed as possible): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In your opinion, what could have prevented this BBFE? (be specific): \_\_\_\_\_

## SECTION 3: NEEDLESTICKS/SHARPS INJURIES

**Was the sharp item:**  Contaminated  Uncontaminated  Unknown

Source of contamination (blood; other—please specify): \_\_\_\_\_

**Depth of injury:**  No visible wound  Superficial (surface scratch)  Moderate (penetrated skin)  Deep puncture or wound

Was the sharp being held?  Yes  No

**If not, was the sharp:**  Hands too close to someone else handling sharp  Being passed by someone else  
 Dropped by someone else  Set aside for future use  Inappropriately discarded or left there by someone else

**Type of sharp:**

<input type="checkbox"/> Needle for blood draw	<input type="checkbox"/> Central line placement	<input type="checkbox"/> Insulin pen
<input type="checkbox"/> Push button butterfly	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Novo Nordisk Innolet (Reg or NPH)
<input type="checkbox"/> Multi sampling needle	<input type="checkbox"/> Introducer	<input type="checkbox"/> Novo Nordisk Flex Pen (Novolog Aspart or 70/30)
<input type="checkbox"/> Slide safety butterfly	<input type="checkbox"/> Scalpel	<input type="checkbox"/> Solostar (Lantus)
<input type="checkbox"/> ABG needle	<input type="checkbox"/> Other	<input type="checkbox"/> Lilly (Humalog)
<input type="checkbox"/> Syringe to draw cord blood		
<input type="checkbox"/> Other		
<input type="checkbox"/> Peripheral IV	<input type="checkbox"/> Huber needle	<input type="checkbox"/> Suture needle
<input type="checkbox"/> Angioset (butterfly)	<input type="checkbox"/> Safety	
<input type="checkbox"/> Angiocath (straight)	<input type="checkbox"/> Non-safety	
<input type="checkbox"/> Needle for injection	<input type="checkbox"/> EMG/SSEP needle	<input type="checkbox"/> Surgical instrument _____

**If administering lidocaine, was needle:**  Being reused  Set aside for reuse  Stuck self while administering  Recapping

If scalpel, was it a safety (retractable) scalpel? \_\_\_\_\_

Do you feel the device was defective?\* \_\_\_\_\_

**\*If YES, please save device for University Health Services if possible.**

## SECTION 4: SPLASHES

Was this exposure related to a splash? \_\_\_\_\_

**Fluid Involved:**  Blood  Urine  Stool  
 Vomitus  Sweat, tears  Saliva, sputum  
 Vent condensation  CSF, synovial, pleural, peritoneal, pericardial, or amniotic fluid

If urine, sweat, vomitus, stool, saliva, sputum, or vent condensation, was fluid visibly bloody? \_\_\_\_\_

What type of personal protective equipment (PPE) was worn during exposure? \_\_\_\_\_

Gloves  Gown  Goggles  Mask with face shield  Mask

**If splashed, fluid came in contact with:**  Intact skin  Non-intact skin  Eyes  
 Nose  Mouth  Other

Did someone else inadvertently splash you? \_\_\_\_\_

If this BBFE was caused by a splash, list barrier protections that could have prevented it: \_\_\_\_\_

**ALL parts of this form MUST be completed by the supervisor in conjunction with the Employee Accident Report.**  
 This form must be submitted directly to Integrated Absence Management and Vocational Services upon completion.

## SECTION 1: PARTICIPANT INFORMATION

Employee's Full Name: First	M.I.	Last	OSU Employee ID#
Supervisor's Full Name: First	M.I.	Last	Phone Number, Ext.
Date report completed: _____		Report completed on date of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## SECTION 2: PERSONAL PROTECTION

**Required Personal Protective Equipment:**

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Respiratory Protection | <input type="checkbox"/> Hearing Protection | <input type="checkbox"/> PPE-Other: |
| <input type="checkbox"/> Head Protection        | <input type="checkbox"/> Hand Protection    |                                     |
| <input type="checkbox"/> Face Protection        | <input type="checkbox"/> Foot Protection    |                                     |
| <input type="checkbox"/> Eye Protection         | <input type="checkbox"/> Fall Protection    |                                     |

**Was Required Personal Protective Equipment used?**  Yes  No

**If not, explain:** \_\_\_\_\_

## SECTION 3: CONTRIBUTING FACTORS OR CONDITIONS

**Period when incident occurred:**  Entering or leaving work  During normal work shift  Overtime or unscheduled work shift

**Unsafe Conditions:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Bypassed Guard or Device             | <input type="checkbox"/> Inadequate Guard       | <input type="checkbox"/> Lack of Required PPE | <input type="checkbox"/> Improper or Defective Clothing |
| <input type="checkbox"/> Defective Safety Device              | <input type="checkbox"/> Inadequate Lighting    | <input type="checkbox"/> Missing Safety Guard | <input type="checkbox"/> Unstable Walking Surface       |
| <input type="checkbox"/> Defective Tool or Article            | <input type="checkbox"/> Inadequate Ventilation | <input type="checkbox"/> Unguarded Hazard     | <input type="checkbox"/> Improper Work Station Layout   |
| <input type="checkbox"/> Training Deficiency (Specify): _____ |   |   |   |

**Unsafe Actions:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Bypassing a safety device         | <input type="checkbox"/> Distractions or horseplay     | <input type="checkbox"/> Operating at an unsafe speed  | <input type="checkbox"/> Using equipment improperly     |
| <input type="checkbox"/> Bypassing a policy or instruction | <input type="checkbox"/> Failure to use approved tools | <input type="checkbox"/> Servicing energized equipment | <input type="checkbox"/> Improper lifting technique     |
| <input type="checkbox"/> Bypassing a safety guard          | <input type="checkbox"/> Failure to wear approved PPE  | <input type="checkbox"/> Using defective equipment     | <input type="checkbox"/> Improper posture or ergonomics |

**Was a witness statement submitted with the Employee Accident Report?**  Yes  No

Upon completion of this Supervisor Accident Analysis Report 1) the following details were found to have occurred, and 2) corrective measures will be taken as follows: