

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 OPAC 2250, Pavilion
2050 Kenny Road
Columbus, OH 43212
Phone: 614-685-3357

Hours: M–F, 4 p.m.–9:30 p.m., SAT–SUN, 10 a.m.–5:30 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

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): _____

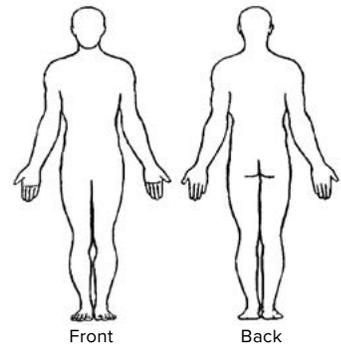
Did employee seek medical treatment? Yes No

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.**

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 (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: