EMPLOYEE INCIDENT / INJURY REPORT
Ottawa County – Policy No. 36200001

*TO BE COMPLETED **BY EMPLOYEE** IN THE EVENT OF AN INCIDENT AND / OR INJURY:*

Your Name:	Date of Birth:
Home Address:	Telephone Number:
City, State, Zip:	Male or Female:
Department/Division:	Shift Worked (start and end time):
Job Title:	Years of Service:
Date & Time of Incident:	Exact Location Where Incident Occurred:
Were you injured?	

EMPLOYEE STATEMENT OF INCIDENT

Describe the cause of the incident including (1) what you were doing **just before** the incident and (2) what you did **immediately after** the incident. **Be sure to include any persons, objects, or substances involved**.

List the names of **any and all** witness:

Did you report the incident to anyone?	If yes, when and to whom?

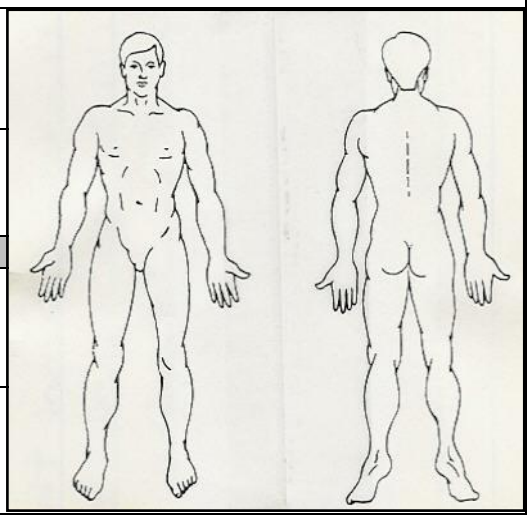
If no, why not?

Your supervisor at time of incident:

What type of injury, if any, did you experience? **Be as specific as possible.** Ex. – strain, sprain, pain/soreness, laceration, bruise, pulled muscle, burn, bite, fracture, contusion, etc.

What were the contributing factors? Ex: slippery floor, lack of available help, lack of training on task performed, etc.

Could something have been done differently to prevent the incident?



EMPLOYEE INJURY INFORMATION

What specific body parts were affected as a result of the incident?
Indicate affected areas on the diagram on the right as well as listing here.

Was first aid administered on site?_____ If yes, please describe (i.e. ice applied, cleaned & bandaged, etc.).

Did you seek treatment at the Emergency Room, Urgent Care, Occupational Health Clinic or Physician's office? If yes, when?
Name of treating physician and hospital or facility:
Was this an aggravation of a previous injury/re-injury? If yes, when was the previous injury?
Did the previous injury occur at work?
Please provide any other information relevant to this report that hasn't already been asked.
Medical Release: *"I hereby consent and grant permission for my employer, Ottawa County, or any representative / agent of my employer, to examine all treatment records from any provider related to this injury. I further grant permission to contact all employers and former employers regarding any and all matters relating to examination, diagnosis, care and treatment of myself, and earnings or loss of earnings. I further consent and grant permission for the employer's representative and/or agent to examine any and all claims and related documents I have on file with the Bureau of Workers' Compensation and/or Industrial Commission of Ohio. I authorize that a photocopy of this Release be accepted with the same authority as the original."* **NOTE**: Under HIPAA, healthcare providers may release protected health information in a workers' compensation claim for treatment, payment or health-care operations purposes.

Employee Signature:	Date:

SUPERVISOR'S STATEMENT
Describe the incident as it was reported to you, including when you were notified, by whom, and any others with knowledge of the incident. **Be sure to include any persons, objects, or substances involved**.
Was the incident a result of horseplay or a violation of a safety procedure? If so, describe.
Did the employee receive specific training relating to the safety and health of the job being performed? If so, when?
Action to be taken:

Supervisor Signature:	Date: