HRD - DIVISION OF EMPLOYEE BENEFITS,
WORKERS COMPENSATION
1180 S. Main St., Suite 378
AKRON, OHIO 44301
Phone:(330)926-2496 ◆ Fax:(330)643-8625

INJURY/ILLNESS REPORT

FORWARD ORIGINAL OF THIS REPORT TO YOUR AGENCY/DEPARTMENT WORKERS COMPENSATION REPRESENTATIVE

PART I: EMPLOYEE'S STATEMENT (PLEASE PRINT, USE BLACK OR BLUE INK ONLY)

NAME ____________________ ADDRESS HOME ____________________

CITY __________ ZIP CODE ________ PHONE # (HOME) __________ PHONE # (WORK) __________

SS# __________ DATE OF BIRTH __________ AGE ________ MALE/FEMALE __________

AGENCY/DEPARTMENT EMPLOYED BY ____________________

JOB TITLE ____________________ COMPLETE ADDRESS OF WHERE YOU REGULARLY REPORT TO WORK ____________________

DATE OF INJURY/ILLNESS ______________ TIME OF INJURY/ILLNESS ______________ AM/PM

DID THE INCIDENT OCCUR: BEFORE, DURING OR AFTER YOUR WORK SHIFT? ______________

DID THE INCIDENT OCCUR WHILE AT WORK ON A NORMAL SHIFT OR WHILE ON OVERTIME? ______________

DID THE INCIDENT OCCUR WHILE ACTUALLY ENGAGED IN WORK FOR THE COUNTY, WHILE COMING TO WORK, ON BREAK OR LEAVING WORK? ______________

COMPLETE ADDRESS OF LOCATION OF INJURY/ILLNESS ______________

____

WAS THIS LOCATION ON THE EMPLOYER'S PREMISES? ________YES ________NO

DESCRIBE INJURY/ILLNESS (PART OF BODY EFFECTED AND NATURE OF INJURY OR ILLNESS) ______________

____

____

____

IDENTIFY THE DUTIES PERFORMED WHEN THE ACCIDENT OR EXPOSURE OCCURRED ______________

____

____

DESCRIBE IN DETAIL THE EVENTS WHICH RESULTED IN THE INJURY OR ILLNESS (FOR AN INJURY: WHAT WERE YOU DOING? HOW DID IT HAPPEN? INCLUDE SPECIFIC OBJECTS, SUBSTANCES AND/OR MACHINES INVOLVED. IF YOU WERE LIFTING AN OBJECT, GIVE APPROXIMATE SIZE, WEIGHT AND DISTANCE LIFTED. FOR AN ILLNESS: DESCRIBE THE SUBSTANCE AND DETAILS OF HOW YOU WERE EXPOSED TO THE SUBSTANCE AND TYPE OF WORK YOU WERE DOING.)

____

____

____

____

WAS THERE ANY PROPERTY DAMAGE? ________YES ________NO IF YES, WHAT PROPERTY WAS DAMAGED? __________

____

____

WERE THERE INJURIES TO OTHER EMPLOYEES OR THE PUBLIC? ________YES ________NO IF YES, WHO WAS INJURED?

(INCLUDE PHONE # WHERE INJURED PARTY CAN BE REACHED) ______________

DID YOU RECEIVE MEDICAL TREATMENT? ________YES ________NO IF YES, DESCRIBE ______________

____

NAME, COMPLETE ADDRESS AND PHONE # OF DOCTOR, HOSPITAL OR OTHER FACILITY PROVIDING SERVICE __________

____

____

NAME OF WITNESS(ES), COMPLETE ADDRESS AND PHONE # ______________

____

____

WITNESS(ES) STATEMENTS ATTACHED? ________YES ________NO WHEN DID YOU REPORT THE INJURY/ILLNESS?

______/_____/______ TO WHOM DID YOU REPORT THE INJURY/ILLNESS? ______________

DATE OF THIS REPORT ______/_____/______ SIGNATURE OF EMPLOYEE ______________

* IF YOU RECEIVE MEDICAL TREATMENT FOR YOUR INJURY/ILLNESS, PLEASE SUBMIT YOUR MEDICAL DOCUMENTATION TO YOUR SUPERVISOR WHEN YOU RETURN TO WORK.

PART II: SUPERVISOR'S REPORT

INJURED WORKER'S NAME ____

NATURE OF INJURY/ILLNESS (STATE EMPLOYEE'S COMPLAINTS) ____

____

____

REMARKS/OBSERVATIONS ____

____

____

DID EMPLOYEE DIE? ________YES ________NO DID EMPLOYEE REPORT BACK TO WORK? _______YES _______NO

IF YES, EMPLOYEE'S RETURN TO WORK DATE ______/_____/______ IF THE EMPLOYEE HAS NOT RETURNED TO WORK, WHAT IS THE ESTIMATED RETURN TO WORK DATE? ______/_____/______

DATE INJURY/ILLNESS WAS REPORTED TO YOU? ________ TIME INJURY/ILLNESS WAS REPORTED TO YOU? _______ AM/PM

DID THE INJURED WORKER PROVIDE A MEDICAL RELEASE UPON RETURNING TO WORK? ________YES ________NO

PLEASE ATTACH THE MEDICAL RELEASE TO THE INJURY/ILLNESS REPORT FORM. (AN EMPLOYEE IS NOT PERMITTED TO RETURN TO WORK UNLESS THEY SUBMIT A MEDICAL RELEASE FROM THEIR MEDICAL PROVIDER)

DID THE MEDICAL RELEASE INCLUDE RESTRICTIONS? ________YES ________NO

IF THE MEDICAL RELEASE INCLUDES RESTRICTIONS, DO THE RESTRICTIONS KEEP THE INJURED WORKER FROM PERFORMING HIS/HER ORIGINAL JOB FUNCTIONS? (JOBS FUNCTIONS PERFORMED AT LEAST (1) ONE TIME PER WEEK) ________ YES __________ NO

CAN THE EMPLOYER ACCOMMODATE THE INJURED WORKER RESTRICTIONS? _________ YES _________ NO

THE INJURED WORKER IS CLASSIFIED AS A (CHECK ONLY ONE)

________FULL-TIME ________INTERMITTENT ________PART-TIME ________RELIEF WORK ________OTHER

WHAT ACTIONS, EVENTS OR CONDITIONS CONTRIBUTED MOST DIRECTLY TO THIS ACCIDENT? ______________________________

____

____

PRIOR TO THIS ACCIDENT, WERE ANY NEAR-MISSES REPORTED? _______YES _______NO IF SO DESCRIBE (INCLUDE DATES OF NEAR-MISSES)

____

____

DESCRIBE WHAT HAS BEEN DONE OR WILL BE DONE TO ELIMINATE OR MINIMIZE THE CAUSES LISTED ABOVE __________

____

____

SUPERVISOR'S NAME (PLEASE PRINT) ____

WORK NUMBER_______________________________ E-MAIL ADDRESS ____

SUPERVISOR'S SIGNATURE ____

TITLE ____ DATE SIGNED _____/_____/_________

DEPARTMENT/DIVISION HEAD'S NAME (PLEASE PRINT) ____

WORK NUMBER_______________________________ E-MAIL ADDRESS ____

DEPARTMENT/DIVISION HEAD'S SIGNATURE ____

TITLE ____ DATE SIGNED _____/_____/_________

SUPPLEMENTARY RECORD OF OCCUPATIONAL INJURIES AND ILLNESSES

THIS FORM CAN BE USED IN PLACE OF THE OSHA NO. 301P, AND IS TO BE USED TO SUPPLEMENT THE LOG AND SUMMARY OF OCCUPATIONAL INJURIES AND ILLNESSES (OSHA NO. 300P). EACH ESTABLISHMENT MUST MAINTAIN A RECORD OF EACH RECORDABLE OCCUPATIONAL INJURY OR ILLNESS. THIS REPORT MUST ALSO BE AVAILABLE IN THE ESTABLISHMENT WITHOUT DELAY AND AT A REASONABLE TIME FOR EXAMINATION BY A REPRESENTATIVE OF THE DEPARTMENT OF LABOR AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND STATES ACCORDED JURISDICTION UNDER THE ACT. OSHA RECORDS MUST BE MAINTAINED FOR A PERIOD OF NOT LESS THAN FIVE YEARS FOLLOWING THE END OF THE CALENDAR YEAR TO WHICH THEY RELATE.

TO BE COMPLETED BY THE WORKERS' COMPENSATION PERSONNEL [OSHA NO. _________________]