THE OHIO STATE UNIVERSITY

# Employee Accident Report

## 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
McCampbell 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

## 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):

_____

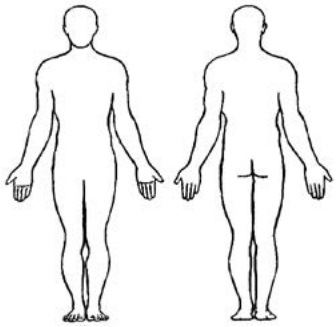
**For blood/body fluid exposure, the Addendum (on page 3) must be fully completed.**

Hospital Medical Record# of source patient: _____

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

| | L | R |
|---|---|---|
| Eyes/Ears/Face | ☐ | ☐ |
| Neck/Shoulders/Arms/Elbows | ☐ | ☐ |
| Hips/Legs/Knees | ☐ | ☐ |
| Wrist/Hands/Fingers | ☐ | ☐ |
| Ankles/Feet/Toes | ☐ | ☐ |
| Back (Upper/Lower) | ☐ | |
| Head | ☐ | |
| Internal Organs | ☐ | |

Other: _____



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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

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# Blood/Body Fluid Exposure Addendum

**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:**

☐ Needle for blood draw
- ☐ Push button butterfly
- ☐ Multi sampling needle
- ☐ Slide safety butterfly
- ☐ ABG needle
- ☐ Syringe to draw cord blood
- ☐ Other

☐ Central line placement
- ☐ Lidocaine
- ☐ Introducer
- ☐ Scalpel
- ☐ Other

☐ Insulin pen
- ☐ Novo Nordisk Innolet (Reg or NPH)
- ☐ Novo Nordisk Flex Pen (Novolog Aspart or 70/30)
- ☐ Solostar (Lantus)
- ☐ Lilly (Humalog)

☐ Peripheral IV
- ☐ Angioset (butterfly)
- ☐ Angiocath (straight)

☐ Huber needle
- ☐ Safety
- ☐ Non-safety

☐ Suture needle

☐ Needle for injection ☐ EMG/SSEP needle ☐ 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: _____

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# Supervisor Accident Analysis Report

**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? ☐Yes ☐No

## SECTION 2: PERSONAL PROTECTION

**Required Personal Protective Equipment:**

☐ Respiratory Protection
☐ Head Protection
☐ Face Protection
☐ Eye Protection
☐ Hearing Protection
☐ Hand Protection
☐ Foot Protection
☐ Fall Protection
☐ PPE-Other:

**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:**

☐Bypassed Guard or Device ☐Inadequate Guard ☐Lack of Required PPE ☐Improper or Defective Clothing
☐Defective Safety Device ☐Inadequate Lighting ☐Missing Safety Guard ☐Unstable Walking Surface
☐Defective Tool or Article ☐Inadequate Ventilation ☐Unguarded Hazard ☐Improper Work Station Layout
☐Training Deficiency (Specify): _____

**Unsafe Actions:**

☐Bypassing a safety device ☐Distractions or horseplay ☐Operating at an unsafe speed ☐Using equipment improperly
☐Bypassing a policy or instruction ☐Failure to use approved tools ☐Servicing energized equipment ☐Improper lifting technique
☐Bypassing a safety guard ☐Failure to wear approved PPE ☐Using defective equipment ☐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: