8442-1F EMPLOYEE ACCIDENT REPORT

*Give one copy to the employee, keep one copy in your school file and send one copy of the accident report **within 24 hours** by e-mail or fax to:*
Linda Webber, Workers' Compensation • Telephone: (513) 363-0161 • **Fax: (513) 842-2433**• E-mail: webberl@cpsboe.k12.oh.us

The Accident Report must be competed and faxed to 513.842.2433 within 24 hours of the time of accident occurred. If the employee is unable to complete the report, the principal/supervisor should complete the report. The employee should then complete a report as soon as he or she is able.

The employee section includes questions 1-25. Every question must be completed. Do not leave any question blank.

1. Complete the date the accident was report to employer.
2. PRINT the name of the school location where employee is assigned.
3. PRINT injured person's name.
4. PRINT injured person's job title.

5-13 COMPLETE as indicated.

14. IDENTIFY the specific location of the accident, e.g. classroom 402, gymnasium, etc.
15. DATE of the accident.
16. TIME of the accident.
17. **YOU MUST CALL within 24 hours 1-888-222-5681 to report your injury.**
18. DESCRIBE specifically what happened. DESCRIBE what you were doing.
19. IDENTIFY nature of injury (check appropriate box(s).
20. IDENTIFY part(s) of the body injured (check appropriate box(s).
21. IDENTIFY if medical treatment was received and if so, where?
22. LIST last day worked.
23. LIST date returned to work.
24. LIST total work days lost.
25. PRINT name(s) and title(s) of witness (es).
26. TO BE COMPLETED BY SUPERVISOR/PRINCIPAL (interview witness (es).
27. TO BE COMPLETED BY SUPERVISOR/PRINCIPAL (cause of accident).
28. TO BE COMPLETED BY SUPERVISOR/PRINCIPAL (correction action taken/recommended).

- **FAX THE ACCIDENT REPORT TO:** **513.842.2433** **Attention:** **Linda Webber**
  Education Center, 3rd Floor
  513.363.0161 (office)
- PLEASE MAKE COPIES:

  COPY #1: Give to the employee
  COPY #2: Retain in your school file

8442-1F EMPLOYEE ACCIDENT REPORT

Instructions: This form must be completed and signed as specified by the employee and the supervisor/principal immediately, but no later than 24 hours after the work-related injury or illness. If the employee is unable to complete the report, the supervisor/principal shall complete the report. The employee shall then complete a report as soon as he or she is able. **By signing this document, employees and supervisors/principals attest to the validity and completeness of the information in the report. Any falsification of information on the accident report may result in disciplinary action up to and including termination.**

FOR OFFICE USE ONLY

Date Received:	**Code:**	**Claim #**__________	**#Prev. Claims** ______	**MCO/CE** ________
	SN: ____	**BWC Claim #** __________		**Hire Date:** ________

TO BE COMPLETED BY EMPLOYEE (please print)

1. Date Accident Reported:	**2. School/Building:**		
3. Employee Name:	**4. Job Title:**		
5. Employee Address:	**6. City:**	**7. State:**	**8. Zip Code:**
9. Home Telephone (with area code):	**10. Work Telephone:**		
11. Employee ID # or Last 4 Digits of SSN:	**12. Date of Birth:**	**13. Sex:** ☐ **Male** ☐ **Female**	
14. Place of Accident:	**15. Date of Accident:**	**16. Time:**	

17. If you received "medical treatment" for your injury, you must call 1-888-222-5681 to report your injury.
Medical Health Care Provider: Tri-Health Bethesda Care-Norwood, 4805 Montgomery Road, Suite 130, 513.853.1040 Open 7AM-6PM

18. Description of Accident/Injuries: (How did the accident happen? Describe what you were doing. You may attach an additional document if necessary.)

19. Nature of Injury: *(check applicable)*
- ☐ **Abrasion** ☐ **Burn** ☐ **Poisoning**
- ☐ **Amputation** ☐ **Concussion** ☐ **Puncture**
- ☐ **Asphyxiation** ☐ **Fracture** ☐ **Sprain**
- ☐ **Bruise** ☐ **Laceration** ☐ **Strain**
- ☐ **Other:** ***(specify):***

20. Part(s) of the Body Injured: *(check applicable)*
- ☐ **Head** ☐ **Leg (L/R)** ☐ **Toe** ***(specify):***
- ☐ **Eye (L/R)** ☐ **Foot(L/R)** ☐ **Finger** ***(specify):***
- ☐ **Shoulder (L/R)** ☐ **Back** ☐ **Other** ***(specify):***
- ☐ **Arm (L/R)** ☐ **Ribs/Chest**
- ☐ **Hand (L/R)** ☐ **Abdomen**

21. Medical Treatment Received: ☐ **Yes** ☐ **No** **If yes, where:**

22. Last Date Worked:	**23. Date Returned to Work:**	**24. Days Lost:**

25. Name and Title of Witness(es):

Please fax report to: Linda Webber, Workers' Comp (513) 842.2433 within 24 hours or e-mail: webberl@cpsboe.k12.oh.us
Telephone: (513) 363.0161 with any questions

TO BE COMPLETED BY SUPERVISOR/PRINCIPAL (please print)

26. Witness(es) Interviewed: ☐**Yes** ☐ **No** ☐ **Statement(s) Attached**

27. Cause of Accident:

28. Corrective Action Taken/Recommended and by whom:

__________		______	__________	______
Signature of the Employee ***(or person completing form if employee unable)***	**Phone**	**Date**	**Signature of Supervisor/Principal**	**Date**