PROCEDURES FOR REPORTING WORKPLACE INJURIES

UPDATED: OCTOBER, 2019

CONTACT: Environment Health and Safety/Workers Compensation Administrator, eghbalc@cpsboe.k12.oh.us (wk) 513-363-0107

Packet includes:

- "Procedures for Reporting Workplace Injuries" instruction cover sheet
- Employee Accident Report Form – with instructions on back side
- Instructions Poster
- Assault Form – with instructions on back side (complete only if applicable; contact HR for questions)

Employee Responsibilities:

- **REPORT** the injury immediately to your Supervisor of Manager
- **COMPLETE** the Employee Accident Report Form *(available at School Main Office & fax to 513.842.2433)*
- **SEEK** immediate medical attention if needed.
  - IF MEDICAL TREATMENT is REQUIRED: Call and report accident to 1-888-222-5681 at Sheakley UniComp.
  - Seek medical attention at: TriHealth Occupational Medicine – Norwood (preferred location) 4805 Montgomery Road, Ste. 130 45212 *(See additional locations attached.)*
- **FOLLOW** treatment instructions as defined by your provider.
- **COMMUNCIATE** your treatment plan to your manager or supervisor and the CPS Workers' Compensation Technician. Please be aware you will be contact by the Ohio Bureau of Workers' Compensation (BWC) MCO and CPS' Third Party Administatror.
- **COMPLETE** the Human Resourses Assault form where appropriate and forwarded to HR directly. *(Call HR at 513-363-0132 with questions regarding the Assault Leave Form.)*
- **QUESTIONS?**
  - Contact: Linda Webber, CPS WC Technician at 513.363.0161 for Workers Compensation related questions
  - Call HR at 513-363-0132 with questions regarding the Assault Leave Form.

Supervisor / Manager Responsibilities:

- **ASSIST** the injuried worker in obtaining immediate medical assistance, if needed.
- **ENSURE/FAX** the injured worker completes an Emplyee Accident Report Form *(available at School Main Office & fax to 513.842.2433)*
- **INVESTIGATE** the injury to ensure appropriate safety and precautionary measures are in place.
- **MAINTAIN** communication with the injured worker and CPS WC Technician and MCO.
- **FORWARD** completed Employee Accident Report Form to the CPS WC Tecnician in a timely fashion *(fax to 513.842.2433)*
- **REQUEST** assistance for the EHS Office on accident investigations where needed.

Our primary goal is to get you proper medical care and help you to return to work full duty.

See additional resources online at the EHS/WC website at:

https://sites.google.com/a/cpsboe.k12.oh.us/environmental-health-and-safety/workers-compensation---employees

including:

- Instructions to follow if injured and require medical attention
- BWC Injured Employee Handbook (outside link)
- BWC Basics for the Injured Worker Handbook (outside link)

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

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

CPSEmployeeAccidentForm

Revision: 4/7/17

What to do *if you're injured on the job...*

WHERE TO GO...

#1 ***Report injury to Supervisor .***
Complete Employee Accident Report Form available at School Main Office & fax to ***513.842.2433***
Questions? Contact: ***Linda Webber,*** *CPS WC Technician at* ***513.363.0161***

#2 ***IF MEDICAL TREATMENT is REQUIRED: Call & report accident*** *to* ***Adrian Walker***
1-888-222-5681
at Sheakley UniComp.

#3 ***Seek medical attention at:***
TriHealth Occupational Medicine – Norwood
(preferred location)

4805 Montgomery Road, Ste. 130
45212

#4 *Update all medical information by calling 1-888-222-5681 to Adrian Walker at Sheakley.*

Norwood
4805 Montgomery Rd.
Suite 130
Cincinnati, OH 45212
Monday – Friday
7 a.m.– 6 p.m.
513.853.1040

Other Occupational Medicine Center Locations

Arrow Springs
100 Arrow Springs Blvd., Ste. 1200; Lebanon, OH 45036
Monday–Friday, 8 a.m.–5 p.m.
513.853.1040

Butler County
8500 Bilstein Blvd. (formerly Berk Blvd.) Hamilton, OH 45015
Monday–Friday, 8 a.m.–5 p.m.
513.853.1040

Eastgate
4452 Eastgate Blvd., Ste. 101 Cincinnati, OH 45245
Monday–Friday, 8 a.m.–5 p.m.
513.853.1040

Queensgate
1150 W. 8th St., Ste. 120 Cincinnati, OH 45203
Monday–Friday, 8 a.m.–5 p.m.
513.853.1040

Sharonville
3801 Hauck Rd. Cincinnati, OH 45241
Monday–Friday, 7 a.m.–7 p.m. Saturday,
9 a.m.–3 p.m.
513.853.1040

Cincinnati Public Schools
Department of Human Resources

Notification of Assault

____________________	____________________	____________________
Name (Print full name)	Title	School
____________________	____________________	____________________
Home Address	Zip Code	Telephone

______________________ ______________________________________

Date of Assault Where Assault Occurred

Name of assailant(s) (grade if applicable) Witness(es)

______________________________ ______________________________

______________________________ ______________________________

Please describe the assault. Attach second page if needed.

____

____

____

____

____

____

Were charges filed? No __________ Yes ________ When ____________________

______________________ ______________________________________

Date Signature

If you were physically disabled from performing your duties as a result of the described assault and want to apply for assault leave, please complete the reverse side.

Distribution: (Original) Director, Human Resources
(Copies) ____ Principal ____ Employee ____ Union

Cincinnati Public Schools
Department of Human Resources

Request for Assault Leave

I hereby certify that I have been physically disabled from performing my duties as a result of the described assault which occurred in the course of my employment.

☐ Medical attention was required.
(If checked, have physician complete below)

☐ Medical attention was not required

▲ I understand that falsification, of either this signed statement or the physician's certificate, is grounds for suspension of termination of employment under Section 3319.16 of the Ohio Revised Code.

_________________________ ____

Date Employee's Signature

▲ I have investigated this matter and attest to the fact that this employee was assaulted.

_________________________ ____

Date Principal's Signature

▲ Date(s) of Absence ____

Physician's Form

This is to certify that ____

Employee's name (print)

has been under my professional care because of

____

____

____

Anticipated date for return to work is ______________________________

_________________________ ____

Date Physician's Signature

HR 2019

Distribution: (Original) Director, Human Resources

(Copies) _____ Principal _____ Employee _____ Union