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Cleveland State University

Accident/Incident Report (Applicable for Employees, Students, Visitors)

Instructions for Report completion:

Complete the form in its entirety within 24 hours of the accident/incident occurrence and send to the Director of Environmental Health and Safety, Plant Services Building Room 210. Phone: (216) 687-9306 Fax (216) 687-9346. PLEASE PRINT ALL INFORMATION.

IMPORTANT: All CSU Employees must sign the form, and also obtain their supervisor's signature on the report form. Forward a copy of the completed form to Human Resources/Benefit Services, Fax (216) 687-3976

Affected Individual's Relationship to CSU (Check one):

- Employee Student Visitor

Individual Identification

1. Date/Time of Accident/Incident _____
2. Full Name _____
3. Street Address _____
4. City/State/Zip Code _____
5. Home Phone Number _____
6. Work Phone Number _____
7. Social Security Number _____
8. Date of Birth _____

CSU Employees Only:

Department _____	Campus Extension _____
Supervisor _____	Campus Extension _____
CSU ID# _____	CSU Date of Hire _____
Supervisor Signature _____	

Accident/Incident Information

**9. Location (Indoors – provide building/room # or area such as stairs, hallway etc....
Outdoors – describe area)_____**

10. Was person performing regular job duties at the time of the accident/incident?
 Yes **No**

11. Did injury occur? **Yes** **No**

12. Did loss of property occur? **Yes** **No**

13. Please describe details of accident/incident:

15. If property damage occurred, please describe the loss as best as possible:

16. Were there any witnesses? **Yes** **No**

17. Name, address and phone number of witnesses (if applicable):

18. If injury occurred, please indicate the portion of the body that was injured:

- Left Right
- Hand Finger(s) Arm Elbow Wrist
- Shoulder Neck Face Teeth Eye(s)
- Foot Toe(s) Leg Knee Ankle
- Head Ear(s) Nose Throat Lungs
- Abdomen Groin Lwr Back Mid Back Upr Back

19. Type of injury (cut, sprain, exposure, bruise, burn, etc.)

20. Did the accident/incident involve a slip, trip, or fall? Yes No

21. Did the accident/incident involve lifting? Yes No

22. If lifting was involved, please indicate approximate weight of material being lifted, and how high it was lifted? _____

23. Is this type of work performed on a regular basis? Yes No

24. If injury occurred, did it appear immediately? Yes No

Information Regarding Medical Treatment/Missed Work Time

25. Were you treated by a physician? Yes No

If yes, Physician Name _____ Phone: _____

Date(s) of Treatment _____

26. Did you go to a hospital? Yes No

If yes, Hospital Name _____ Date _____

Hospital Phone _____

CSU EMPLOYEES: For medical attention, please contact the University Health Services (SR 153) at x3649 for an appointment that day. If at all possible, the Health Services will address your need (but please do not just walk in). As an alternative, you may proceed to St. Vincent Charity Hospital Occupational Medicine Center (2322 East 22nd Street) during regular work hours for non-emergency matters. For emergency care, go to the St. Vincent Charity Hospital Emergency Room. Call 2020 for emergency transport.

27. Did you miss work? Yes No

Work Days/Time Missed _____

Return to Work Date _____

CSU EMPLOYEES: Please call Benefits Services at 3636 for Assistance

28. If injury occurred, is the injury an aggravation of an old injury? Yes No

Signature/Authorization

I certify that the information set forth above is true and correct to the best of my knowledge. By signing this form, I authorize any person(s) who did or who may hereafter provide medical attention, examination, or treatment, or who may possess information or knowledge which may be used to render a decision in my claim for injury/disease of _____ (date), to disclose such information or knowledge to my employer and/or to any other agency contracted by my employer to investigate this health claim.

Employee Name (Print)

Employee Signature (Sign)

Date _____

Revised January 18, 2007