ARN#_____

Cleveland State University

Accident/Incident Report

(Applicable for Employees, Students, and Visitors)

Instructions for Report completion:

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

IMPORTANT: All CSU Employees/Students/Visitors 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 _____ a.m. /p.m.**
2. **Full Name_____**
3. **Street Address_____**
4. **City/State/Zip Code_____**
5. **Home Phone Number_____**
6. **Work Phone Number_____**
7. **CSU ID Number_____**
8. **Birth date_____**

CSU Employees Only:
Department_____ Campus Extension_____
Supervisor_____ Campus Extension_____
Supervisor Signature_____
Hire Date_____
Time work shift began a.m. /p.m.
Job Title

Accident/Incident Information

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

10. **Was person performing regular job duties at the time of the accident/incident? N/A for Students** □ **Yes** □ **No**

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

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

13. **Please describe details of accident/incident:**

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

15. **Were there any witnesses?** □ **Yes** □ **No**

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

_____

_____

_____

17. 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**

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

_____

_____

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

20. Did the accident/incident involve lifting? □ **Yes** □ **No**

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

22. Is this type of work performed on a regular basis? □ **Yes** □ **No**

23. If injury occurred, did it appear immediately? □ **Yes** □ **No**

<u>Information Regarding Medical Treatment/Missed Work Time</u>

24. Were you treated by a physician? □ **Yes** □ **No**

If yes, Physician Name_____**Phone:** _____

Date(s) of Treatment_____

25. 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 at 2112 Euclid Ave (CIMP Building) Rm. IM 205 at x3649 for an appointment that day. If at all possible, 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 Medical Center (2475 East 22nd Street, Suite 310) during regular work hours for non-emergency matters. For emergency care, go to the St. Vincent Charity Hospital Emergency Room. Call Campus Police for an emergency transport.

26. Did you miss work? □ **Yes** □ **No**

Work Days/Time Missed_____

Return to Work Date_____

CSU EMPLOYEES: Please call Benefits Services at x3636 for Assistance

27. . 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/Student/Visitor (Print) **Employee/Student/Visitor (Signature)**

_____ _____

Date_____

Revised, June 2015

Please pass these forms on to your Supervisor when finished

Cleveland State University

Accident/Investigation Report

(Applicable for Supervisors/Directors and Department Head)

Instructions for Report completion:

This form is to be filled out and signed by either a Supervisor/Director and signed by the Department head. This form is a supplemental Report to go along with the Accident/Incident Report that is filled out by the injured person. Please fill it out to its entirety. IMPORTANT-This form is ONLY for your supervisor to fill out and for them only, and not the injured party to review or view. Please forward to EHS when finished.

Name_____

- □ **Employee**
- □ **Student**
- □ **Visitor**

Department_____ **Date/Time of Incident**_____

Type of Injury/Illness_____ **Body Parts Affected**_____

Witnesses: Name/Phone_____

Specific Job being performed at time of accident/incident

_____

Explain what exactly occurred (person's location, what he/she was doing, what occurrence resulted in accident/incident?)

_____

_____

_____

_____

_____

_____

What condition(s) existed, if any that may have resulted in the accident/incident?

_____

_____

_____

Did Employee fail to perform an act that caused or contributed to the accident/incident? If yes, explain_____

_____

_____

_____

What action(s) have been taken or will be taken in the future to prevent recurrence:

_____

_____

_____

Person responsible for corrective action:

_____

Proposed date of planned corrective action: _____

Supervisor's Name_____ **Date**_____

Signature_____

Department Head_____ **Date**_____

Signature_____

Director of Environmental Health and Safety **Date**_____

_____

Revised June 2015