ARN#_____

Cleveland State University
Injury/Occupational Illness Report
(Applicable for Employees, Students, and Visitors)

Instructions for Report completion:
Complete the form in its entirety within 24 hours of the injury/illness.

IMPORTANT: All CSU Employees/Students/Visitors must sign the form, CSU employees must 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.

PLEASE PRINT ALL INFORMATION.

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

□ Employee □ Student □ Visitor

Individual Identification

1. **Date/Time of Injury/Illness _____ 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_____ Supervisor_____
Campus Extension_____
Supervisor Signature_____
Hire Date_____
Time work shift began_____ AM/PM
Job Title_____

Injury/Illness 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 injury/illness? 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 injury/illness:**

_____

_____

_____

_____

_____

_____

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 injury involve a slip, trip, or fall? □ **Yes** □ **No**

20. Did the injury 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 get transported to the hospital? □ **Yes** □ **No**

If yes, Hospital Name_____
Hospital Phone _____ **Date**_____
Was medical treatment declined? □ **Yes** □ **No**

CSU EMPLOYEES:

*** * For non-emergency medical attention, please contact the University Health Services at 2112 Euclid Ave (CIMP Building) Rm. IM 205 at x3649 for an appointment that day.**

**** For emergency care, or if Health Services is not able to accommodate non-emergency treatment, 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, April 2018

Please pass these forms on to your Supervisor when finished

Cleveland State University
Supervisor 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 Injury/Illness 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 Human Resources/Benefit Services Fax (216) 687-3976.

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 injury/illness?

_____

_____

_____

Did Employee fail to perform an act that caused or contributed to the injury/illness? 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_____ **Date**_____

Department Head_____ **Date**_____

Signature_____ **Date**_____

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

_____

Revised, April 2018