ARN# ____________ **Section A**

Cleveland State University Occupational Injury/ 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 Worker ☐ 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

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

Was person performing regular job duties at the time of the injury/illness? (*N/A for Students*) ☐ Yes ☐ No

Did injury occur? ☐ Yes ☐ No

Did loss of property occur? ☐ Yes ☐ No

Please describe details of injury/illness:

____
____
____
____
____

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

____
____
____
____
____

Were there any witnesses? ☐ Yes ☐ No

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

____
____
____
____
____

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**

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

____

____

Did the injury involve a slip, trip, or fall? ☐ Yes ☐ No

Did the injury involve lifting? ☐ Yes ☐ No

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

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

If injury occurred, did it appear immediately? ☐ Yes ☐ No

Information Regarding Medical Treatment/Missed Work Time

Were you treated by a physician? ☐ Yes ☐ No

If yes, Physician Name____________________________________Phone: _____________

Date(s) of Treatment____

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 go to the University Hospitals ER, 11100 Euclid Ave, Cleveland, OH 44106, phone 440-596-5730 or MetroHealth ER, 2500 Metrohealth Dr, Cleveland , OH 44109, phone : 216-778-7800 Please notify CSU Human Resources, at x3636 during business hours (8 am to 5 pm), of the injury and the need to transport for medical attention**

**** For emergency care, or for non-emergency care after business hours, go to the University Hospitals ER, 11100 Euclid Ave, Cleveland, OH 44106, phone 440-596-5730 Call Campus Police for an emergency transport.**

Did you miss work? ☐ Yes ☐ No

Work Days/Time Missed____

Return to Work Date____

CSU EMPLOYEES: Please call CSU Human Resource/Benefits at x3636 for Assistance

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____________________________

Please pass these forms on to your Supervisor when finished

Section B

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 Worker ☐ 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**____________

____