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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:**

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

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

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

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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**

Information Regarding Medical Treatment/Missed Work Time

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

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

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

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

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

____

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____

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_________**

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Revised June 2015