

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

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 Up'r 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

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 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 CSU Human Resource/Benefits 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 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** _____

Revised, April 2018