

Memo

Date: 6-7-00
To: County Chairs, District Directors, ABE Director
Cc: Barbara Ludwig
From: Mark Byers
RE: Accident Reporting Procedure

Some confusion has arisen lately regarding proper accident reporting procedures for OSU Extension employees. With a busy summer and state and county fair season just around the corner, it seems appropriate to review these procedures to be prepared should an injury occur. As always, please call me if you have any questions.

Accident Reporting Procedure:

Obtain and keep on file at all times a copy of the Employee Accident Report form. Rev. 3/99. A copy of this form was mailed to all County and District offices last year and another copy is attached. A copy may also be downloaded at: <http://www.ehs.ohio-state.edu/ohs/accrep.pdf>. Older versions of the Employee Accident Report and Supervisor's Follow-up Report form. Stores #53722 should no longer be used. These are four-page and two-page carbonless forms.

Obtain a completed Employee Accident Report form from the injured employee within 24 hours of the accident if at all possible. If the severity of the injury precludes this, a witness to the accident should fill out the form if one was present.

The employee's supervisor should review and sign the form within 48 hours.

File a copy of the form in the administrative unit's files.

Ensure copies of the Employee Accident Report form are properly distributed. The following parties should all receive copies:

- Employee
- Supervisor
- OSU Workers' Compensation
- OSU Employee Health 614-293-8146
2A University Hospitals Clinic (Room 2100)
456 West 10th Avenue
Columbus, OH 43210
- Mark Byers-OSHAllog Coordinator 614-292-0622
590 W. Woody Hayes Drive-Room 249
Columbus, OH 43210

THE OHIO STATE UNIVERSITY EMPLOYEE ACCIDENT REPORT

The Employee Accident Report must be completed for every work-related accident (form available on Environmental Health and Safety OSU Web page and Employee Health intranet site) This report will:

1. assist employees in obtaining immediate medical treatment
2. inform supervisor/charge person of accident
3. be utilized for follow-up and future prevention.

Below are guidelines for completing this form (please print in ink).

EMPLOYEE RESPONSIBILITIES:

1. Immediately notify supervisor/designated charge person of work-related accident.
2. Fully complete Employee section, sign and date the report. (Please print in ink.)
3. Give form to supervisor/charge person for signature.
4. Seek medical treatment if necessary (see Medical Treatment section below).

SUPERVISOR/CHARGE PERSON RESPONSIBILITIES:

1. Complete Supervisor/Charge Person section. Sign & date the report. If employee needs/desires medical treatment, arrange for appropriate medical care (see Medical Treatment section below).
2. If employee does not need/desire medical treatment make a copy of this report for your records & send the original to Employee Health (note on the form no medical treatment needed at this time).
3. If medical treatment is needed at a later date, refer employee to Employee Health.

MEDICAL TREATMENT:

As an OSU employee you are entitled to medical treatment at OSU Employee Health. There is no charge to you for this treatment.

OSU Employee Health (Rm2100)

2A University Hospitals Clinic Phone: (614) 293-8146 FAX: (614) 293-8018

456 West 10th Avenue Hours: Monday - Friday (excluding holidays)

Columbus, OH 43210

7:30 A.M. TO 4:00 P.M.

If Employee Health is closed for the day come for treatment the next working day.

Or

If you need immediate medical treatment and Employee Health is not open you may go to either the OSU Emergency Department, MEDOHIO West (88 North Wilson Road) or MEDOHIO North (5801 Tamarack Boulevard). They will provide immediate treatment and instruct you in follow up care.

Regional campus employees should be sent to their local health care provider

For Blood and Body Fluid Exposures:

Employee should report blood & body fluid exposures immediately to supervisor. Medical complex personnel should refer to Blood and Body Fluid Exposure Protocol for instructions. All others should call OSU Employee Health (614-293-8146) for instructions.

Submit this report to: OSU Employee Health (fax: 614-293-8018), 2A University Hospitals Clinic, 456 W. Tenth Ave.

OSHA200 "Recordable Code" key from Health Care Provider section on front of form

1. Injury involving loss of consciousness
2. Injury involving restriction of work or motion
3. Injury involves transfer to another job
4. All work related fatalities (deaths)
5. All work related illness
6. All work related injuries involving medical treatment
7. Not recordable

The Ohio State University Employee Accident Report

EMPLOYEE

Name _____ SS# _____ Emp ID _____
Home Address _____

Street city zip code phone
Sex: M F Birth Date _____ Age: _____ Employment Status: Full time _____ Part time _____ %

Job Title _____ Time in Present Position _____ Yrs _____ Month;

Department _____ Work Address _____
name building/room # phone

Supervisor _____
building/room # phone

Accident Date _____ Time _____ am/pm Location _____
What were you doing and using (tools, chemicals, equipment, etc.) when the accident occurred? Describe what happened.

Was this part of your normal job duty? _____ Yes _____ No
Parts of body affected or injured _____

Witnesses: _____ / _____
name phone name phone

Report prepared by (if different from the injured employee) _____
name phone

If you have been exposed to blood or body fluids, refer to Medical Center Blood and Body Fluid Exposure Protocol or call Employee Health at 293-8146 for instructions (see medical treatment section on reverse side)
Hospital Medical Record # or Social Security # of source person _____

I understand that it is my right to apply/or Workers ' Compensation benefits and that I have two years from the date of this accident to do so. For more information regarding workers ' compensation, University and James Hospitals employees call 293-3571; employees in other departments call 292-3439. I also authorize release of medical information regarding this accident to OSU BWC claim administrators.

EMPLOYEE SIGNATURE: _____ DATE: _____

SEND EMPLOYEE FOR TREATMENT WITH THIS FORM TO: EMPLOYEE HEALTH. 2A (Rm. 2100) UNIVERSITY HOSPITALS CLINIC, 456 WEST IOTH AVENUE, WITHIN 72 HOURS AFTER ACCIDENT IS REPORTED
Regional campus employees should be sent to local health care provider.

SUPERVISOR/CHARGE PERSON

This accident was reported to me on _____ at _____ Cost Center/Dept # _____
(date) (time)

IS FURTHER INVESTIGATION REQUIRED? _____ Yes _____ No
Supervisor/Charge Person Signature Date

HEALTH CARE PROVIDER

Treated by: _____
print name signature

Address: _____
name of facility street city state zip code phone

Hospitalized overnight as inpatient? _____ yes _____ no (if emergency room only mark no)
Diagnosis/Assessment _____ RECORDABLE CODE 1234567

Parts of body affected _____
Reaggravation of previous work injury? _____ yes _____ no Date of initial injury _____

Copies sent to: _____ Employee _____ OSHALOG Coord. _____ OSU Workers Comp. _____ OEH&S _____ Supervisor
FAX 688-8120 FAX 292-6404