THE OHIO STATE UNIVERSITY

Employee Accident Report

Read These Instructions Before Proceeding

The Employee Accident Report must be completed for every work-related accident or illness. (Medical complex personnel refer to University Health Services web page on the intranet.) This report will:

1. Assist employees in obtaining immediate medical treatment
2. Inform supervisor/charge person of accident
3. Be recorded for follow-up and future prevention

Below are guidelines for completing this form (please print neatly in ink or complete electronically)

Employee Responsibilities:

1. Immediately notify supervisor/designated charge person of work-related accident or illness.
2. Fully complete "Employee Information" and "Accident Information" sections, sign, and date the report.
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 and date the report. If employee needs or desires medical treatment, arrange for appropriate medical care (see "Medical Treatment" section below).
2. If employee does not need or desire medical treatment, make a copy of this report for your records and send the original to University Health Services (address listed below). If medical treatment is needed at a later date as a result of this accident, refer employee to University Health Services.

Medical Treatment

Send employees for treatment with this form within 72 hours after the accident is reported.

Columbus campus employees should seek treatment for work-related injuries and/or illness at:
OSU University Health Services, McCampbell Hall, 2nd floor
1581 Dodd Drive
Phone: 614-293-8146 • Fax: 614-293-8018
Hours: M–F, 7:30 a.m.–4 p.m.
(There is no cost for medical treatment of employee accidents or injuries at University Health Services.)

If University Health Services is closed or unavailable, seek treatment at:

OSU Occupational Medicine–
CarePoint East
543 Taylor Ave., 2nd floor
Columbus, OH 43203
614-688-6492
Hours: M–F, 8 a.m.–5 p.m.

OSU Occupational Medicine–
CarePoint West
86 N. Wilson Road
Columbus, OH 43204
614-293-3500
Hours: M–F, 8 a.m.–5 p.m.

After Hours Care
Martha Morehouse Medical Plaza
2nd Floor, Suite 2400, Pavilion
2050 Kenny Road
Columbus, OH 43212
614-685-3357
Hours: M–F, 8 a.m.–5 p.m.;
SAT, 10 a.m.–6 p.m; SUN, 10 a.m.–6 p.m.

After normal business hours or on weekends, for non-emergencies, seek treatment at University Health Services during normal business hours. After normal business hours, seek treatment at After Hours Care. If life threatening, seek emergency treatment at Ohio State's Wexner Medical Center Emergency Department or University Hospital East Emergency Department. (Hospital employees should report to University Health Services the next day.)

Regional campus employees should seek treatment at the designated local health care provider.

For blood and body fluid exposures (BBFE): Employees must report blood and body fluid exposures immediately to their supervisor and complete the BBFE Addendum to this report. Wexner Medical Center personnel should refer to Blood and Body Fluid Exposure Protocol for instructions. All others should call University Health Services at 614-293-8146 for instructions.

Submit this report to: University Health Services
University Hospital Clinic
McCampbell Hall, 2nd floor
1581 Dodd Drive
Fax: 614-293-8018

Workers' Compensation Rights

Employees have the right to apply for Workers' Compensation benefits. They have two years from the date of this accident to do so. For more information regarding workers' compensation, call 614-292-3439.

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Employee Accident Report

Section I: Employee Information—all fields must be completed

Name: _____ OSU Employee ID#: _____ ☐ Full Time ☐ Part Time

Home Address: _____ Home Phone: _____

City/State/Zip Code: _____ Date of Birth: _____ Age: _____ Sex: _____

Job Title: _____ Department: _____

Work Address: _____ Work Phone: _____

Supervisor's Name: _____ Supervisor's Phone: _____

Section II: Accident Information—provide as much detail as possible

Accident date/time: _____ ☐ A.M. ☐ P.M. Time shift began: _____ ☐ A.M. ☐ P.M. Date of death, if applicable: _____

Location of accident (room #/building/shop): _____

Briefly explain the accident and what was being done just prior _____

_____

Was this activity part of employee's normal job duty? ☐ Yes ☐ No

What object or substance directly harmed the employee?

_____

Type of injury or illness: _____

Witnesses (name and phone): _____

_____

Did employee seek medical treatment? ☐ Yes ☐ No If Yes, where? _____

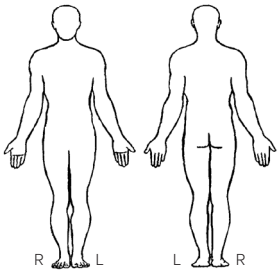
This report prepared by (name and phone, if different from injured employee):

_____

For blood/body fluid exposure, the Addendum (on page 3) must be fully completed.

Hospital Medical Record # of source patient: _____

Body part(s) affected/injured (circle on diagram)



	L	R
Eyes/Ears/Face	☐	☐
Neck/Shoulders/Arms/Elbows	☐	☐
Hips/Legs/Knees	☐	☐
Wrist/Hands/Fingers	☐	☐
Ankles/Feet/Toes	☐	☐
Back (Upper/Lower)		☐
Head		☐
Internal Organs		☐

Other: _____

Please review the Medical Treatment information on page 1 of this form. **If no medical treatment is necessary or if treatment is sought somewhere other than University Health Services (UHS), send a copy of this completed report to UHS at: Fax: 614-293-8018 or McCampbell Hall, 2nd floor, 1581 Dodd Drive.**

Section III: Employee Authorization

I understand that it is my right to apply for Workers' Compensation benefits and that I have two years from the date of this accident to do so. I also authorize release of medical information regarding this accident to OSU BWC claim administrators.

EMPLOYEE SIGNATURE: _____ Date: _____

Section IV: (to be completed by supervisor / charge person)

This accident was reported to me on: Date: _____ Time: _____ Cost Center/Department #: _____

Is further investigation required? ☐ Yes ☐ No If Yes, why? _____

_____ **SUPERVISOR/CHARGE PERSON SIGNATURE:** _____ Date: _____

Section V: (to be completed by health care provider)

Treated by University Health Services? ☐ Yes ☐ No If No, treated by: _____

Medical provider printed name: _____ **MEDICAL PROVIDER SIGNATURE:** _____

Diagnosis/Assessment: _____

Body part(s) affected: _____ Date treated: _____ Reaggravation of a previous injury? ☐ Yes ☐ No

If Yes, date of initial injury: _____ ☐ Full Duty ☐ Restricted Duty Date (if restricted, please use MEDCO-14): _____

OSHA300 Recordable Code(s):

☐ 1 - Injury involving loss of consciousness ☐ 2 - Injury involving restriction of work or lost time

☐ 3 - Injury involves transfer to another job ☐ 4 - All work-related fatalities (death) ☐ 5 - All work-related illness

☐ 6 - All work-related injuries (treatment beyond first aid) ☐ 7 - Not recordable ☐ 8 - Human Bloodborne Pathogen Exposure

Medical Record # _____ Send copies to: (date/initial when sent)

_____ OSU Workers' Compensation Fax: 614-292-0271 _____ University Health Services Fax: 614-293-8018 _____ Supervisor/Dept.

_____ Medical Center Safety Fax: 614-293-8100 _____ OSHALOG Coordinator (see list) _____ Injured employee

_____ Environmental Health & Safety Fax: 614-292-6404

Section VI: Workers' Compensation Self-Insurance (for Integrated Disability use only)

Certification? ☐ Yes ☐ No ORG #: _____

Signature: _____ Date: _____

ATTENTION: This form contains information relating to employee's work-related injury and must be used in a manner that protects the confidentiality of the employee to the maximum extent possible.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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Blood/Body Fluid Exposure Addendum

ALL parts of this form MUST be completed with as much detail as possible.
This form must be sent directly to University Health Services (not to supervisor).

Section I: Employee Information

Name:_____ OSU employee ID#:_____ Date of exposure: _____
Time of exposure:_____ Date of hire:_____ Number of hours on duty:_____
Occupation: _____ Phone # (for reporting lab results):_____ Pregnant: ☐ Yes ☐ No

Section II: BBFE Information

Specific location of exposure (room # and building):_____
Location type (patient room; laboratory; bathroom): _____
Cause of the exposure (splash; needlestick; bite): _____
Detailed account of the event (be as specific and detailed as possible):

_____

_____

In your opinion, what could have prevented this BBFE? (be specific): _____

Section III: Needlesticks/Sharps Injuries

Was the sharp item: ☐ Contaminated ☐ Uncontaminated ☐ Unknown
Source of contamination (blood; other—please specify):_____
Depth of injury: ☐ Superficial (surface scratch) ☐ Moderate (penetrated skin) ☐ Deep puncture or wound
Was the sharp being held? ☐ Yes ☐ No
If not, was the sharp:
☐ Hands too close to someone else handling sharp
☐ Dropped by someone else
☐ Inappropriately discarded or left there by someone else
☐ Being passed by someone else
☐ Set aside for future use

Type of sharp:

☐ Needle for blood draw
- ☐ Push button butterfly
- ☐ Multi sampling needle
- ☐ Slide safety butterfly
- ☐ ABG needle
- ☐ Syringe to draw cord blood
- ☐ Other

☐ Central line placement
- ☐ Lidocaine
- ☐ Introducer
- ☐ Scalpel
- ☐ Other

☐ Insulin pen
- ☐ Novo Nordisk Innolet (Reg or NPH)
- ☐ Novo Nordisk Flex Pen (Novolog Aspart or 70/30)
- ☐ Solostar (Lantus)
- ☐ Lilly (Humalog)

☐ Peripheral IV
- ☐ Angioset (butterfly)
- ☐ Angiocath (straight)

☐ Huber needle
- ☐ Safety
- ☐ Non-safety

☐ Suture needle

☐ Needle for injection

☐ EMG/SSEP needle

☐ Surgical instrument _____

If administering lidocaine, was needle:
☐ Being reused ☐ Set aside for reuse
☐ Stuck self while administering ☐ Recapping

If scalpel, was it a safety (retractable) scalpel? _____
Do you feel the device was defective? _____
****If YES, please save device for University Health Services if possible.**

Section IV: Splashes

Was this exposure related to a splash? _____
Fluid Involved:
☐ Blood ☐ Urine ☐ Stool
☐ Vomitus ☐ Sweat, tears ☐ Saliva, sputum
☐ Vent condensation ☐ CSF, synovial, pleural, peritoneal, pericardial, or amniotic fluid

If urine, sweat, vomitus, stool, saliva, sputum, or vent condensation, was fluid visibly bloody? _____
What type of personal protective equipment (PPE) was worn during exposure? _____
☐ Gloves ☐ Glasses ☐ Mask
☐ Gown ☐ Goggles ☐ Mask with face shield

If splashed, fluid came in contact with:
☐ Intact skin ☐ Non-intact skin ☐ Eyes
☐ Nose ☐ Mouth ☐ Other

Did someone else inadvertently splash you? _____
If this BBFE was caused by a splash, list barrier protections that could have prevented it:

_____