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.
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:

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/ injured (circle on diagram)

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

OSHA300 Recordable Code(s):

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

If Yes, of initial injury: □ Yes □ No Reaggravation of a previous injury? □ Yes □ No

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

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.
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  □ Being passed by someone else
□ Dropped by someone else  □ Set aside for future use
□ Inappropriately discarded or left there by someone else
□ 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  □ Being passed by someone else
□ Dropped by someone else  □ Set aside for future use
□ Inappropriately discarded or left there by someone else
□ Type of sharp:  □ Needle for blood draw  □ Central line placement  □ Insulin pen
□ Push button butterfly  □ Lidocaine  □ Novo Nordisk Innolet (Reg or NPH)
□ Multi sampling needle  □ Introducer  □ Novo Nordisk Flex Pen
□ Slide safety butterfly  □ Scalpel  □ (Novolog Aspart or 70/30)
□ ABG needle  □ Other  □ Solostar (Lantus)
□ Syringe to draw cord blood  □ Other  □ Lilly (Humalog)
□ Other
If administering lidocaine, was needle:  □ Being reused  □ Set aside for reuse  □ Surgical instrument __________
□ Being recapped  □ Recapping
If scalpel, was it a safety (retractable) scalpel? ________________________________________________________________
Do you feel the device was defective? ________________________________________________________________

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: ________________________________

Office of Human Resources, UMC130329, rev. 07/18/13
Employee Accident Report, Page 3 of 3