Today's Date ___/___/___

UNIVERSITY OF TOLEDO

INJURY / ILLNESS REPORT FOR EMPLOYEES, STUDENT EMPLOYEES AND STUDENTS

EMPLOYEE INFORMATION	STUDENT EMPLOYEE INFORMATION	STUDENT INFORMATION
❑ Full time ❑ Part time	❑ Full time ❑ Part time	
Name: _____	Name: _____	Name: _____
Department: _____	Department: _____	College of: _____
Dept. Extension _____ Shift 1 2 3	Dept. Extension _____	Telephone #: _____
Job Title: _____	Telephone #: _____	

DATE OF INJURY OR ONSET OF ILLNESS: ____/____/____

TIME OF INCIDENT: _____ am pm

WHERE DID THE INCIDENT occur? ❑ Health Science Campus ❑ Main Campus

INDOORS Bldg. _____ Room/Area _____ OUTDOORS Area _____

EVENT

- ☐ Fall
- ☐ Slip/Trip, No Fall
- ☐ Lifting/Moving
- ☐ Tool/Object Injury
- ☐ Illness
- ☐ Vehicle Accident
- ☐ Stuck/Injured by Patient
- ☐ Other _____
- ☐ Lifting/Moving

EXPOSURE Patient # _____

- ☐ Clean Needlestick/Sharp
- ☐ Contaminated Needlestick/Sharp
- ☐ Human Bite
- ☐ Communicable Disease Exposure
- ☐ B/B Fluid, Intact Skin
- ☐ B/B Fluid, Non-intact Skin
- ☐ B/B Fluid, Mucous Membrane
- ☐ Chemical / Biohazard Exposure

MISCELLANEOUS

- ☐ Employee Concern
- ☐ Employee/MD Behavior
- ☐ Radiation Exposure
- ☐ Non-Compliance Exposure Control Plan
- ☐ Ergonomic Concern
- ☐ Latex Reaction
- ☐ Chemical/Biohazard Spill

Substance: _____

INJURY SUSTAINED? ☐ Yes ☐ No

- ☐ Bruise/contusion
- ☐ Puncture/laceration
- ☐ Sprain/Strain
- ☐ Burn
- ☐ Fracture
- ☐ Foreign Body
- ☐ Laser Injury
- ☐ Unconscious
- ☐ Other: _____

INJURED BODY PARTS (Indicate the part of the body that was affected, and how it was affected. BE SPECIFIC _____

MEDICAL ATTENTION NEEDED? ☐ Yes ☐ No Seen by M.D.? ☐ Yes ☐ No

- ☐ Bandaid
- ☐ Ointment
- ☐ Ice
- ☐ Elevation
- ☐ "Ace" Wrap
- ☐ Taken to ER
- ☐ X-rays
- ☐ Sutures
- ☐ Hospitalized
- ☐ Splint
- ☐ Medication (List below)

What was the injured/ill person doing when the incident occurred? _____

Description of Incident: _____

Name of Person Reporting (PLEASE PRINT) _____ Extension _____ WITNESS: _____ Extension _____

THIS FORM DOES NOT INITIATE A WORKER'S COMPENSATION CLAIM

MANAGERS ONLY COMPLETE THIS SECTION

Actions/Notes: _____

Supervisor's Signature _____ Date: _____

Do not write in this space

2/08

SUPERVISOR'S ANALYSIS

UNIVERSITY OF TOLEDO

Accident/Injury/Illness

The Public Employees Risk Reduction Program of the State of Ohio requires prompt reporting of accidents, therefore this document needs to be completed and submitted to Safety & Health without delay. Accidents don't just happen - your thorough analysis of this event could prevent it from happening again. Use facts and avoid speculation. Call Safety & Health (X3600 Main Campus) for help if necessary.

Subject / Employee			Incident Date _____/_____/_____
All accidents result from unsafe acts or conditions such as horseplay, violation of procedure, poor visibility, inadequate training, equipment failures/malfunctions or ineffective/inadequate safety designs. Interview the subject and any witnesses and visit the scene to establish facts about the incident. ❑ UNSAFE ACT ❑ UNSAFE CONDITION			
DESCRIBE			
Based on the available facts, summarize your findings as to the cause(s) of the incident.			
List machinery, equipment, tools, chemicals or other significant factors:			
Was the accident fatal? (Contact Safety & Health immediately at 419-530-3600)	❑ Yes	❑ No	❑ N/A
Was the employee trained in the skills necessary to perform the task involved in the accident?	❑ Yes	❑ No	❑ N/A
Was the employee performing his/her normal work function?	❑ Yes	❑ No	❑ N/A
Were necessary guards or safety devices installed?	❑ Yes	❑ No	❑ N/A
Was personal protective equipment required?	❑ Yes	❑ No	❑ N/A
Was personal protective equipment correctly worn?	❑ Yes	❑ No	❑ N/A
List possible preventative or corrective action(s):			
Completed by: (PRINT)	Title:	Phone:	
Signature		Date _____/_____/_____	

10/07