UNIVERSITY OF TOLEDO

Today's Date ____/____/____

INJURY / ILLNESS REPORT FOR EMPLOYEES, STUDENT EMPLOYEES AND STUDENTS

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

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
- ☐ Struck/Injured by Patient
- ☐ Other ______

INJURY SUSTAINED? ☐ Yes ☐ No

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

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

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

MISCELLANEOUS

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

Substance: ______

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: ______

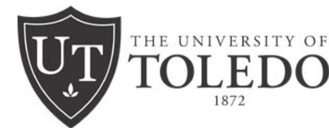
Supervisor's Signature ______ Date: ______

Do not write in this space

3/2021

UNIVERSITY OF TOLEDO

INJURY / ILLNESS REPORT FOR EMPLOYEES, STUDENT EMPLOYEES AND STUDENTS



Do not use this form for incidences involving patients, medications or medical equipment

INSTRUCTIONS FOR INJURY/ILLNESS REPORT COMPLETION
ONLY UT EMPLOYEES OR STUDENTS SHOULD INITIATE, COMPLETE, AND SIGN THE INJURY / ILLNESS REPORT

1. Enter the date that you are filling out the form in the top left corner.
2. Complete the appropriate box for employee, student employee or student information.
3. Fill in the injury/illness date and time, and where the incident occurred (BE SPECIFIC).
4. Under "EVENT", "EXPOSURE", OR "MISCELLANEOUS", check box that best describes the event.
5. If event is an "EXPOSURE" from a patient, fill in patient record number.
6. Next, indicate whether or not there was an injury, and check box that best describes that injury.
7. Then list the body parts that were injured (example: L 4th finger, R lower back).
8. Complete the section "MEDICAL ATTENTION NEEDED?", indicating whether employee was seen by a doctor and what treatment was received.
9. Explain what the injured/ill person was doing before the incident occurred and a full description of what happened.
10. Whoever is completing the report should then print their name and extension. This is not necessarily the employee that was injured or became ill.
11. If there is a witness to the event, print their name and extension.
12. Any exposure to biological agents in research must be reported to the Biosafety Officer.

MANAGERS/SUPERVISORS

1. Describe any actions taken, including any medical treatment or exposure protocol addressed in University Health Services.
2. Managers **must** review and sign/date the form.
3. Send the completed form to the **Environmental Health & Radiation Safety (EHRS)** Department on the Health Science Campus at Mail Stop 1078, or to Risk Management on the Main Campus at Mail Stop 220.

INCOMPLETE FORMS WILL BE RETURNED TO SUPERVISORS FOR PROPER COMPLETION

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 **EHRS** 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 **EHRS at 419-530-3600** 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:

Question	Yes	No	N/A
Was the accident fatal? (Contact **EHRS** 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 ______/______/______