



## Central State University (CSU) ACCIDENT PROCEDURE

Note: Copies of all injury reporting packets are located in your department office and/or Human Resources Department.

**Complete this form when the answer to all of these questions is “Yes”:**

- 1. Did the employee become ill or injured while on CSU property?**  
*Example: Did the employee fall on ice in the parking lot while walking in to the building to start their shift? Did the employee suffer an injury from falling, while experiencing a seizure or epileptic episode? Did the employee become nauseated after smelling fumes caused by cleaning materials?*
- 2. Did the employee’s injury or ailment arise out of and in the course of their Employment?**  
*Example: Did the employee experience a cut/scrape while taking out the trash? Did a professor fall in the classroom while on their way to assist a student?*
- 3. Is it likely that a Workers Compensation Claim will be filed by the employee?**

➤ **IF IT IS A LIFE-THREATENING EMERGENCY AND AN AMBULANCE IS NEEDED:**

### Supervisor’s Responsibilities:

1. Call 911
2. Complete Parts 4, 5, 6 & 7 of the Accident Report.
3. Complete Parts 1, 2, and the Body Diagram of the Accident Report (only if the employee is unable to complete).
4. Provide Part 3 to the Witness and request that they complete their section of the report
5. Take pictures of the accident site, if the site is relevant (raised sidewalk, etc.).
6. Scan and email the Accident Report to:
  - Human Resources Dept. – [HR@centralstate.edu](mailto:HR@centralstate.edu)
  - Department head of the department to which injured employee resides.
7. If medical treatment is required, please have the FROI- First Report of Injury completed by the injured employee
8. A MedCo-14 must be completed and returned to the injured employees’ supervisor after seeking medical treatment as well as a doctor’s release must be provided before the employee may return to work.

### Employee's Responsibilities:

1. If possible, complete Parts 1, 2, and the Body Diagram Form of the Accident Report.
2. If not possible, Parts 1 and the Body Diagram will be completed by the Supervisor and/or Human Resources.
3. **Part 2 must be completed by the employee upon returning to work.**
4. If medical treatment is required, please have the FROI- First Report of Injury completed by the injured employee
5. A MedCo-14 must be completed and returned to the injured employees' supervisor after seeking medical treatment as well as a doctor's release must be provided before the employee may return to work.

### Witness's Responsibilities:

1. Complete Part 3 of the Accident Report.

### Human Resources Responsibilities:

1. Follow up with the Supervisor to obtain updated or incomplete information
2. Ensure that the employee has been released by their doctor to return to work.
3. Update Accident Report and Doctor's Release

### ➤ **IF MEDICAL TREATMENT IS NEEDED IMMEDIATELY (BUT NOT BY AMBULANCE):**

### Supervisor's Responsibilities:

1. Complete Parts 4, 5, 6 & 7 of the Accident Report.
2. Complete Parts 1, 2, and the Body Diagram of the Accident Report (only if employee is unable to complete)
3. Provide Part 3 to the Witness and request that they complete their section of the report
4. Take pictures of the accident site, if the site is relevant (raised sidewalk, etc.).
5. Scan and email the Accident Report to:
  - a. Human Resources Dept. – [HR@centralstate.edu](mailto:HR@centralstate.edu)
  - b. Department head of the department to which injured employee resides.
6. If medical treatment is required, please have the FROI- First Report of Injury completed by the injured employee
7. A MedCo-14 must be completed and returned to the injured employees' supervisor after seeking medical treatment as well as a doctor's release must be provided before the employee may return to work.
8. Give original Accident Report to Human Resources.

### Employee's Responsibilities:

1. If possible, complete Parts 1, 2, and the Body Diagram Form of the Accident Report.
2. If not possible, Part 1 and the Body Diagram Form will be completed by the Supervisor or Human Resources Coordinator.
3. **Part 2 must be completed by the employee upon returning to work.**
4. If medical treatment is required, please have the FROI- First Report of Injury completed by the injured employee
5. A MedCo-14 must be completed and returned to the injured employees' supervisor after seeking medical treatment as well as a doctor's release must be provided before the employee may return to work.

### **Witness's Responsibilities:**

1. Complete Part 3 of the Accident Report.

### **Human Resources Responsibilities:**

1. Follow up with the Supervisor to obtain updated or incomplete information
2. Update the Accident Report
3. Ensure that the employee has been released by their doctor to return to work.
4. If applicable, record the accident information into your Accident Log.

### **➤ IF NO MEDICAL TREATMENT IS NEEDED:**

### **Supervisor's Responsibilities:**

1. Complete Parts 4, 5, 6 & 7 of the Accident Report.
2. Complete Parts 1, 2, and the Body Diagram of the Accident Report (only if employee is unable to complete)
3. Provide Part 3 to the Witness and request that they complete their section of the report
4. Take pictures of the accident site, if the site is relevant (raised sidewalk, etc.).
5. Scan and email the Accident Report to:
  - a. Human Resources Dept. – [HR@centralstate.edu](mailto:HR@centralstate.edu)
  - b. Department head of the department to which injured employee resides.
6. Give original Accident Report to Human Resources.

### **Employee's Responsibilities:**

1. Complete Parts 1, 2, and the Body Diagram Form of the Accident Report.
2. If not possible, Part 1 and the Body Diagram Form will be completed by the Supervisor or Human Resources Coordinator.
3. **Part 2 must be completed by the employee upon returning to work.**

### **Witness's Responsibilities:**

1. Complete Part 3 of the Accident Report

### **Human Resources Responsibilities:**

1. Follow up with the Supervisor to obtain updated or incomplete information
2. Scan and email updated Accident Report to:
  - a. Human Resources Dept. – [HR@centralstate.edu](mailto:HR@centralstate.edu)
  - b. Department head of the department to which injured employee resides.

**Central State University**

To: **Scan and Email to:**

- c. Human Resources Dept. – [HR@centralstate.edu](mailto:HR@centralstate.edu)
- d. Department head of the department to which injured employee works.

From: \_\_\_\_\_ Date: \_\_\_\_\_

**Central State University  
Office of Human Resources  
1400 Brush Row Road  
P.O. Box 1004  
Wilberforce, OH 45384  
Phone: (937) 376-6540  
Fax: (937) 376-6245**

**ACCIDENT REPORT**

To be completed by employee:

**PART 1 IDENTIFICATION INFORMATION**

Employee Name \_\_\_\_\_

Employee Home Address \_\_\_\_\_

\_\_\_\_\_

City	State	Zip
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Home Telephone ( ) \_\_\_\_\_ SSN \_\_\_\_\_ - - \_\_\_\_\_

Date of Hire \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ **AM / PM**

Occupation \_\_\_\_\_

Department \_\_\_\_\_

Accident Location: \_\_\_\_\_

Was employee performing their regular job at the time of accident / illness?

- Yes                       No

Was employee on paid break or unpaid break at time of incident?

Paid Break       N/A

Unpaid Break

**PART 2      EMPLOYEE STATEMENT CONCERNING ACCIDENT**

1. What were you doing when the accident occurred?

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2. Was anyone around to witness the accident?

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3. How did the accident occur?

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4. Where were you injured?

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This is my description of the accident. A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

As provided by Section 4123.651 (c) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my Workers' Compensation claim to the Industrial Commission of Ohio, the Ohio Bureau of Workers' Compensation, the employer in this claim, the employer's managed care organization and any authorized representative, as such medical information, records and reports may possibly pertain to a condition either allowed or alleged in my claim, or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Workers' Compensation claim. A copy shall be as good as the original.

By \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_  
(Signature)

Home Address \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

**PART 3 WITNESS STATEMENTS TO ACCIDENT**

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By \_\_\_\_\_ Position: \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

City

State

Zip Code

Home Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

**PART 4 SUPERVISOR STATEMENTS TO ACCIDENT**

Fully Describe Accident \_\_\_\_\_

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What Factors Led to the Accident? \_\_\_\_\_

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By \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

City

State

Zip Code

Home Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

**PART 5 ATTACH ADDITIONAL COMMENTS, REPORTS AND TIME/DATED PHOTOS HERE**

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**PART 6 SUPPLEMENTARY INFORMATION**

Did the injured employee seek outside medical treatment?

Yes

No

**If the employee sought medical treatment, please provide the following information:**

Name and Address of Physician or Treatment Facility: \_\_\_\_\_

\_\_\_\_\_  
City

State

Zip Code

If Hospitalized, Name and Address of Hospital \_\_\_\_\_

\_\_\_\_\_  
City

State

Zip Code

Was the Employee Drug and Alcohol Tested?

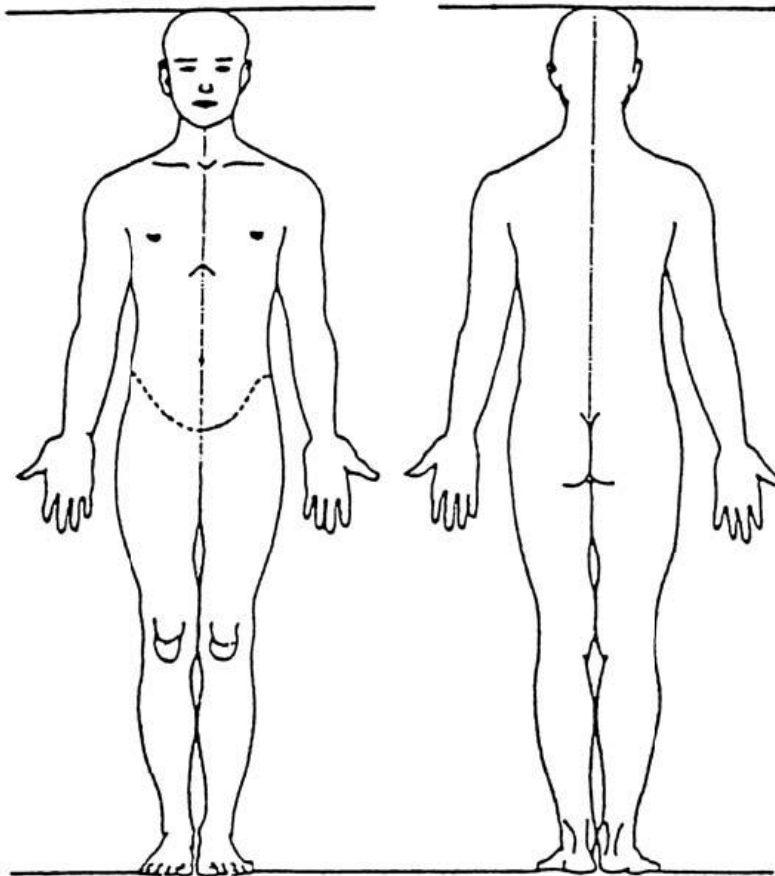
Yes

No

## BODILY INJURY CHART

**Instructions:**

On the body diagram below, indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Date: \_\_\_\_\_