Revised: August 25, 2014

TRI-COUNTY EDUCATIONAL SERVICE CENTER
ACCIDENT REPORT and ANALYSIS WORKSHEET

("All information" must be completed and signed by "Employee's Immediate Supervisor" (injured employee and supervisor signatures are required), and "promptly" submitted to TESC Safety Manager at 741 Winkler Dr., Wooster, OH 44691)

Administrator submitting form:____________________ **Date**:__________

I. EMPLOYEE INFORMATION (Please Print or Type)

Employee Name ____________________ Social Security Number ____________________

Job Title/Program/Address ____________________ Days of Week Worked__________

Work Schedule: Hours _________am _________pm #__________Days/wk Wage Rate __________

DOB __________ Sex ☐Male ☐Female Marital Status __________ Number of Dependents________

Employee Street Address ____________________ City ____________________

State __________ Zip __________ Work Phone ( )__________Home Phone ( ) __________

Date Employed ____________________ Email____________________
(*Contact Treasurer's Office if not known*)

II. INJURY/TREATMENT/LOCATION INFORMATION: Date of Injury or Onset of Symptoms________Time________AM/PM *(Circle One)*

Name of location and address of injury____________________

Specific part(s) of the body that were injured (right, left, etc.)____________________

Accident Event and Location: Briefly describe **exactly what happened and specific location**; include injured person's comments (be specific – identify any objects or substances that were involved; continue on back of page as necessary):

____
____
____

Was **first aid** administered? ☐Yes ☐No If so, by whom? ____________________Phone: ( )__________

Was **other medical treatment provided**? ☐Yes ☐No If so, **by whom**?____________________Phone ( )__________

TREATMENT FACILITY:

Facility Name:____________________**Address:**____________________Phone: ( )__________

Time (if left work for medical treatment) __________ (AM/PM), **Emergency Room**? ☐Yes ☐No Return Time__________ (AM/PM)

Was the **party providing treatment BWC Certified**? ☐Yes ☐No

III. OTHER IMPORTANT INFORMATION:

To **whom/when** was the **injury reported**?____________________ Date/Time __________

Will injury likely cause **loss of time worked**? ☐Yes ☐No Was **previous injury aggravated**? ☐Yes ☐No

Briefly state previous injury type/date:____________________

Similar injury in the past? ☐Yes ☐No When (date)?__________ Where?____________________

PERRP Training____________________ *(Most Recent Date & Location or TCESC On-Line PERRP)*

Date last worked__/__/__ **Date returned to work**__/__/__ **Number of Calendar Days Out**__/__/__ **Total Days Restriction**__/__/__

If Traffic Accident during work schedule: Specific location____________________Who was cited?__________

Going from (point of departure)____________________to (destination)____________________ **(Must submit copy of Police Report)**

IV. WHAT HAS BEEN (WILL BE) DONE TO PREVENT A REOCCURRENCE OF THE ACCIDENT? __________

____
____
____

WITNESSES TO THE ACCIDENT:

V. WITNESS STATEMENTS (Please Print or Type)

Name____Work Phone (   )____________ Home Phone (   )____________

Did you see an accident involving the listed employee: ☐Yes ☐No When?_________ Where? ____________________________

Describe what you saw:

____

____

____

____

____

Witness Signature ___________________________________Printed Name ______________________________Date___________

VI. MEDICAL RELEASE SIGNED BY INJURED EMPLOYEE

Under current Workers' Compensation Law, the employer is entitled to a signed medical release. I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, my employer's managed care organization, or to my employer's designated representative.

Injured Employee Signature _________________________________Printed Name _______________________Date___________

VII. SUPERVISOR CONFIRMATION OF REPORT INFORMATION (Signature)____

Date ____________________ Phone (   )________________________

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VIII. SAFETY MANAGER'S REVIEW/COMMENTS:

Signature ______________________________ Date ___/___/___ Restriction Days? ☐Yes ☐No Follow up required? ☐Yes ☐No

Comments:

(Date Report Received - ____________________)____

(First Report of Injury to BWC By:____ Date:__________________)