UNIVERSITY OF Cincinnati

INITIAL REPORT ON WORK-RELATED INJURY or ILLNESS

This report must be completed and signed by the employee immediately, but no later than 24 hours, after an occupational/work-related injury or illness. The supervisor must sign and forward the report immediately after an employee submits the report. If the employee is not available to complete the report, the supervisor must complete the report for the employee.

This form is not an insurance form. Cases listed below are not necessarily eligible for Worker's Compensation or other insurance. Listing a case below does not necessarily mean that the employer or the worker was at fault or that an OSHA Standard was violated.

TYPE OR PRINT IN INK. ATTACH ADDITIONAL PAGES IF YOU NEED EXTRA SPACE.

1. **Has a fatality occurred?** ☐ No ☐ Yes If yes, date of death (mo./day/yr.) ____/____/____
2. **Employee Name** (last, first, middle) _____
3. **Date of Birth** (mo./day/yr.) ____/____/____
4. ☐ **Female** ☐ **Male**
5. **UCID number** M ☐☐☐☐☐☐☐☐
6. **Date Hired** (mo./day/yr.) ____/____/____
7. **Home Address** (# and street, city, state, and zip code) _____
8. **Home Phone** (____) _____–_____
9. **Job Title** _____
10. **Dept. Phone** (____) _____–_____
11. **Department** _____
12. **Time employee began work** _____ ☐ a.m. ☐ p.m.
13. **Date of injury or illness (mo./day/yr.)** ____/____/____
14. **Time of injury or illness** _____ ☐ a.m. ☐ p.m.
15. **Was employee on duty at the time?** ☐ Yes ☐ No
16. **Is this a new injury or illness?** ☐ Yes ☐ No
17. **Did injury or illness occur on UC premises?** ☐ Yes ☐ No
18. **Location of Incident** (Building & Rm.) _____
19. **Name(s) and Phone(s) of Witness(es)** _____ ☐ No Witnesses
20. **Name of Supervisor Notified** _____ **Date & Time Notified** _____
21. **Did employee receive medical treatment following this incident?** ☐ Yes ☐ No
22. **Medical Facility** (name, phone, and address) **Date of Treatment** _____
23. **Name of physician/health care professional** _____
24. **Was employee treated in an emergency room?** ☐ Yes ☐ No
25. **Was employee hospitalized overnight as an in-patient?** ☐ Yes ☐ No
26. **Check Part(s) of Body Affected and circle Right/Left**
    ☐ Head (R / L) ☐ Face and Neck (R / L) ☐ Eye (R / L) ☐ Trunk/Internal Organs (R / L)
    ☐ Arm (R / L) ☐ Hand (R / L) ☐ Leg (R / L) ☐ Feet (R / L)
    ☐ Upper Back (R / L) ☐ Lower Back (R / L) ☐ Other _____
27. **Check Specific Type of Injury or Illness**
    ☐ Fracture ☐ Foreign Body ☐ Bruise ☐ Cut
    ☐ Burn ☐ Sprain or Strain ☐ Other _____
28. **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key entry."

    _____

    _____
29. **What happened?** Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

    _____

    _____
30. **What object or substance directly harmed the employee?** Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

    _____
31. **Who completed this form?** ☐ Injured employee ☐ Supervisor ☐ Other _____ **32. Date completed** _____

I certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. Furthermore, I understand the information I supplied may be audited by the University or its representatives. I understand that falsifying this document may be grounds for disciplinary action up to and including termination of employment. In addition, I may be in violation of Federal and/or State laws and subject to prosecution.

33. _____ _____
Employee's Signature **Date**

I have reviewed this report and acknowledge its receipt.

34. _____ _____ _____
Supervisor's Signature **Date** **Phone number**

SEND REPORT TO: Original - Environmental Health & Safety, ML 0218 Copy - Retain in Departmental Business Office Fax - Human Resources, 556-9652 Copy - Provide to Employee	**ENVIRONMENTAL HEALTH & SAFETY OFFICE USE ONLY**	**FORM A-1352 (a)** **Rev. 01/11**

ALL WORK-RELATED INJURIES AND ILLNESSES ARE INVESTIGATED BY ENVIRONMENTAL HEALTH & SAFETY