Columbus City Schools
Employee Injury Report

A. PERSONAL INFORMATION

1. Name_____ S. S. No. _____
Last First Middle

2. Home Address _____
No. & Street Name City State Zip Code

3. Date of Birth_____ Age _____ Sex _____ Marital Status_____

4. Home Phone # (___)_____ Work Phone # (614) 365 - _____

B. WORK INFORMATION

5. Job Title:_____

6. Building:_____

C. INJURY INFORMATION

7. What job duties were you performing when you were injured?_____

_____

8. Describe in detail how your injury occurred:_____

_____

_____

9. **DATE**, Time and Location of injury?_____

10. If the injury resulted from lifting/handling objects what was the approximate weight of the objects_____

11. How high did you lift the object? Who helped you? What did you use to lift it?_____

_____

12. Did the injury occur on CCS property? ❒ Yes ❒ No

13.

TYPE OF INJURY (e.g., bruise, cut, fracture etc.)	INJURED BODY PART (e.g., left arm, lower back, right index finger etc.)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

D. PHYSICIAN/HOSPITAL INFORMATION

14. Clinic/Hospital Name_____Date of First Visit_____

15. Attending Physician Name_____Admitted to clinic/hospital? ❒ Yes ❒ No

16. Physician Address_____ Phone Number_____

E. WITNESS INFORMATION

17. _____
(NAME) (TITLE) (WORK PHONE)

_____
(NAME) (TITLE) (WORK PHONE)

Injured employee's signature required on the bottom of the next page.

Submit to Treasurer's Office within two business days of accident.

F. SUPERVISOR'S EVALUATION

18. CAUSE OF INJURY:

A. Defective or improperly guarded equipment? ❒ **Yes** ❒ **No**

If "Yes" checked, complete the following:

Type of Equipment_____ Model#/License #_____

Has equipment been modified or repaired?_____If yes, what corrective measures were taken?_____

_____ Date of correction_____

If no correction was made, explain why:_____

B. Unsafe Acts

Improper body position or work method	❒ Yes	❒ No
Improper use of equipment	❒ Yes	❒ No
Inattention	❒ Yes	❒ No
Horseplay	❒ Yes	❒ No
Violation of safety regulation	❒ Yes	❒ No
Failure to use personal protective equipment properly	❒ Yes	❒ No
Other	❒ Yes	❒ No

If "Yes" checked above, describe the unsafe act:_____

_____

What direction was given to the employee?_____

C. Unsafe Conditions

Weather related	❒ Yes	❒ No
Slippery or uneven walking surfaces	❒ Yes	❒ No
Sudden, unavoidable conditions or situations	❒ Yes	❒ No
Other	❒ Yes	❒ No

If "Yes" checked above, describe the unsafe condition:_____

_____

What was done to eliminate this unsafe condition?_____

_____

D. Other Cause (Please explain):_____

_____

19. What will you recommend to eliminate and/or reduce the workplace risk?_____

_____

20. What actions have you taken to prevent this injury from happening again?_____

_____

21. When were you first notified of this injury? Date_____Time_____AM/PM

22. Did the employee leave work as a result of this injury? ❒ **Yes** ❒ **No** Last day worked_____Time_____AM/PM

23. Has the employee returned to work? ❒ **Yes** ❒ **No** Date returned to work_____Time_____AM/PM

24. Are you in agreement with this claim? ❒ **Yes** ❒ **No** If not, explain why:_____

G. SUPERVISOR'S SIGNATURE: _____

Signature Date

H. EMPLOYEE'S SIGNATURE: _____

Signature Date

Attach any additional documents or comments and submit to Treasurer's Office within two business days of accident.