Revised: January 24, 2014

# TRI-COUNTY EDUCATIONAL SERVICE CENTER
# ACCIDENT REPORT and ANALYSIS WORKSHEET

**(“All information” must be completed and confirmed by “Employee’s Immediate Supervisor” (signed by injured employee and supervisor), and “promptly” submitted to TESC Safety Manager at 741 Winkler Dr., Wooster, OH 44691)**

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## 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)*

**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? ______________________

______________________________

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**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 - ______________)______________________________________________

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