

EMPLOYEE'S REPORT OF INCIDENT AND INJURY
PLEASE PRINT IN INK To be completed by Employee

Employer:

Name _____	Social Sec. No. _____
Home Address _____	Birth Date _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip _____	Telephone: () _____

Date of injury or onset of symptoms _____ Time _____ am pm
Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:** _____

Did anyone see you get hurt? Yes No If yes, who? _____
Did you report this incident to anyone? Yes No If not, why not? _____
If yes, to whom did you report it? _____ Title/Position _____ When? _____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull) _____

Was any first aid provided at the scene? Yes No If yes, describe: _____

Did you seek other medical treatment? Yes No If yes, when? _____
Where? _____ If treatment was not sought immediately, explain why: _____

Is this an aggravation of a previous injury/symptom? Yes No If yes, when were you last treated for the previous injury?
_____ By whom or where? _____

Have you ever had a similar injury? Yes No If yes, describe other injury: _____

Medical Release

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, **CompManagement, LLC**. A copy of this form will serve as the original.

Employee Name (print) _____

Employee Signature _____ Date (required) _____

EMPLOYEE'S REPORT OF INCIDENT AND BACK INJURY

To be completed when a back injury is reported

PLEASE PRINT IN INK

Employer:

Name _____	Social Sec. No. _____
Home Address _____	Birth date _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip _____	Telephone: () _____
Occupation _____	Department _____

What part of your back hurts now? _____

When did you first notice this back pain? Date _____ Time _____ am pm

What were you doing at that time (explain **in detail**)? _____

If you were lifting an object, what was it and how heavy? _____

What was your exact position when pain was first noticed? _____

What did you feel? _____

What was the length of time between the injury and your disability, if any? _____

Did anyone see you get hurt? Yes No If yes, who? _____

Did you report or mention this injury to anyone? Yes No If yes, who? _____ When? _____

Did you ever have a back injury before? Yes No If yes, when? _____

What part of your back? _____

Were you ever treated by a doctor? Yes No If so, when? _____

Has it given you further trouble since then? _____

Have you ever received or filed for compensation because of a back injury? Yes No

Any other injury? Yes No If yes, list Bureau of Workers' Compensation claim number(s) _____

Medical Release

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, **CompManagement, LLC**. A copy of this form will serve as the original.

Employee Name (print) _____

Employee Signature _____ Date (required) _____

OCCUPATIONAL DISEASE OR ILLNESS REPORT
PLEASE PRINT IN INK **To be completed by Employee**

Employer:

Name _____	Social Sec. No. _____
Home Address _____	Birth date _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip _____	Telephone: () _____
Occupation _____	Department _____

Date of injury or onset of symptoms _____	Time _____ <input type="checkbox"/> am <input type="checkbox"/> pm
Type of job performed when symptoms first appeared _____	
Number of months/years in above job _____	
Number of months/years total with this employer _____	

Did you report or mention your symptoms to anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to whom? _____
What was the length of time between the onset of your symptoms and your disability, if any? _____
Will the condition require further treatment or prevent you from working? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____

Date of diagnosis or first treatment for this condition _____	Current diagnosis _____
Doctor's name, address and phone: _____	

Have you ever experienced this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain in full detail: _____

Medical visits during the last five years: _____

Current medications prescribed by your doctor(s); include doctor's name: _____

Medical Release	
<i>Under current workers' compensation law, the employer is entitled to a signed medical release</i>	
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, CompManagement, LLC . A copy of this form will serve as the original.	
Employee Name (print) _____	
Employee Signature _____	Date (required) _____

STATEMENT OF WITNESS TO ACCIDENT

Employer:

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident _____ Shift _____

Occupation _____ Department _____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name _____ Your occupation _____

Your address _____ Your telephone number () _____ - _____

Did you see an accident involving the above employee? Yes No

If not, how did you learn about the accident? _____

If you did see an accident occur: Date of accident _____ Time of accident _____ am pm

Describe what you saw: _____

Your signature _____ Please print your name _____ Date _____

State of Ohio ¶

County of _____ ¶

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at _____, Ohio this _____ day of _____, 19_____.

(SEAL)

(signed) _____

Name (printed or typed) _____

Notary Public, State of Ohio

My Commission Expires _____ (date)

SUPERVISOR'S INVESTIGATION REPORT

Employer: _____
Employee Name: _____ **Soc. Sec. #** _____
Date of Injury: _____

Was an investigation completed concerning the circumstances of this injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were there any witnesses to this injury? If yes, witness statements should be attached.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has there been any recent disciplinary action taken against this employee? If yes, please describe: _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the employee missed any work previously due to similar industrial or non -industrial conditions? If so, when? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has the employee submitted medical documentation for the injury? If so, please attach.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If known, please provide us with the name, address and telephone number of the attending physician: _____ _____ _____ _____		

Has the employee returned to work? Last day worked _____ Returned to work _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If not, what is the current estimated date of return? _____		

With the information you have, would you recommend the claim be accepted? If no, why? _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Employer's signature	Title	Date
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PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.