APPENDIX V
LAKE COUNTY BOARD OF MR/DD
8121 DEEPWOOD BLVD., MENTOR, OH 44060
EMPLOYEE ACCIDENT/INJURY/ILLNESS REPORT

_____
Report Number
Assigned in H.R.

Part I For the Employee

Instructions: **PLEASE PRINT.** All items below are to be completed by the employee on the day of the accident/injury/occupational illness. Retain a completed copy for your files, forward a copy to the Human Resources Analyst within 24 hours. Call the Human Resource Analyst as soon as you are aware of the accident/injury/occupational illness. **Call the Human Resource Analyst the day you return to work**. Do not utilize any consumer name or consumer information. If necessary, use codes, i.e., Consumer 1, Consumer, 2, Employee 1, Employee 2 etc.

Name (Please Print) _____
Gender _____ M ___ F Department _____ Job Title _____
Social Security No. _____
I, certify that on: (Month) _____ (Day) _____ (Year) _____ at ___ AM/PM,
I sustained an injury illness.

Describe the injury/illness in detail indicating body part/s affected (e.g., burns, fractures, abrasions, sprains, etc.) _____
_____
_____
Which happened as follows (name object/substance causing injury/illness): _____
_____
_____
_____
_____
_____
_____
Location of Accident/Injury/Illness _____
On LCBMR/DD Property _____ YES _____ NO
Name of Witnesses, if any: (1) _____
(2) _____
Does the illness/injury require medical attention? _____ YES _____ NO
Where will you go for medical attention? _____

I hereby certify that this accident/illness occurred as stated above.

Employee's Signature _____ Date _____

Attach additional pages if more space is needed.

Part II For the Supervisor

Instructions: **PLEASE PRINT.** All items below are to be completed by the supervisor on the day of the accident/injury/occupational illness. Retain a completed copy for your files, forward a copy to the Human Resources Analyst within 24 hours. Call the Human Resource Analyst as soon as you are aware of the accident/injury/occupational illness. **Call the Human Resource Analyst the day the employee returns to work.** If an accident is fatal or involved serious injury or if you have reasonable cause to suspect that the employee may be intoxicated or under the influence of a controlled substance, call the Superintendent, Operations Director, or Human Resources Director as soon as possible.

Print full name of injured employee _____

Employee is _____ Full Time _____ Part Time _____ Substitute

Other (Explain) _____

State Employee's normal work schedule: (Days) _____ (Hours) _____

Nature of injury/illness: (Employee's complaints and body part/s injured) _____

_____

_____

How did injury/illness occur? _____

_____

_____

Additional information pertinent to injury/illness: _____

_____

_____

Did this occur on LCBMRDD property? _____ YES _____ NO

Was first aid given? _____ YES _____ NO

Did employee seek medical treatment? _____ YES _____ NO Where?_____

_____ Did employee die? _____ YES _____ NO

Did you observe this accident/injury? _____ YES _____ NO Are you aware of witnesses?

_____ YES _____ NO (If yes, attach statements.)

Is injury/illness consistent with employee's statements? _____ YES _____ NO

If no, please explain _____

_____

_____

Did the employee return to work? _____ YES _____ NO Actual date returned _____

If no return date is established within 24 hrs., make a copy of this form and send to the Human Resources Analyst:

Print Name/Title _____

Signature _____ Date _____

Human Resources Analyst Signature _____ Date _____

Attach additional pages if more space is needed