ACCIDENT INFORMATION REPORT

Return to Benefits Administration at +0602 or Fax to (330) 972-2336

A. THIS SECTION TO BE COMPLETED & SIGNED BY EMPLOYEE.

LAST NAME – FIRST NAME – MIDDLE NAME	EMPLOYEE ID#	DATE OF BIRTH	SEX	JOB TITLE

HOME ADDRESS	PHONE NUMBER	DEPT NAME	REPORTED TO DEPT. SUPERVISOR DATE: TIME:

DATE & TIME OF INCIDENT	LOST TIME □ YES □ NO	RETURN TO WORK DATE	LOCATION OF ACCIDENT (Be Specific)

EMPLOYEE' S STATEMENT - INDICATE HOW, WHEN, WHERE INJURY OCCURRED & DESCRIBE PART OF BODY INJURED:

NATURE OF INJURY:	WAS FIRST AID GIVEN? □ Yes □ No
□ Fracture □ Laceration □ Strain/Sprain □ Burn □ Foreign Body □ Other _____	DID YOU GO TO THE DOCTOR? □ Yes □ No IF YES, PLEASE GIVE NAME. _____
NAME OF WITNESSES:	HAVE YOU FILED FOR WORKERS' COMPENSATION BEFORE? □ Yes □ No IF YES,WHERE?

I, the injured employee, herein certify that the information set forth above is true and correct to the best of my knowledge.

Employee Signature: _____ **Date:** _____

B. THIS SECTION TO BE COMPLETED & SIGNED BY SUPERVISOR.

DESCRIPTION AND APPARENT CAUSE OF ACCIDENT:

IF PROPERTY/EQUIPMENT INVOLVED, DESCRIBE DAMAGE:

WHAT WAS INJURED DOING WHEN INCIDENT OCCURRED?

CORRECTIVE ACTION RECOMMENDED:

WAS ACCIDENT DUE TO UNSAFE EQUIPMENT OR CONDITION?

Supervisor's Signature _____ **Date:** _____

C. THIS SECTION TO BE COMPLETED BY INVESTIGATOR.

HAS INVESTIGATION BEEN MADE? □ YES □ NO IF YES, ON WHAT DATE? _____

INVESTIGATIOR'S REMARKS & RECOMMENDATIONS:

RECOMMENDATION FOR FILING CLAIM: □ APPROVED □ DISAPPROVED

Investigator's Signature _____ **Date:** _____