EMPLOYEE'S REPORT OF INCIDENT AND INJURY

PLEASE PRINT IN INK

To be completed by Employee and sent to workplaceinjury@cscc.edu

Employer: Columbus State Community College 550 East Spring Street, P.O. Box 1609, Columbus, Ohio 43216

Name________________________________ Employee CID________________________________

Home Address________________________________ Birth Date________________ Sex: ☐ Male ☐ 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:**________________

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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):

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

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

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Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?________________________________

Where?________________________________ If treatment was not sought immediately, explain why: ____________

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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:________________________________

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Medical Release

Under current workers' compensation provisions, 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, Inc.** A copy of this form will serve as the original.

Employee Name (print)________________________________

Employee Signature________________________________ Date (required)________________________

COLUMBUS STATE
COMMUNITY COLLEGE

CompManagement, Inc.