

CITY OF KENTON

EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee * OSHA 301 Info in BOLD

Name: _____	Social Sec. No. <u>XXX-XX-</u> _____ (Last 4-digits only)
Home Address: _____	Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City/State/Zip: _____	Telephone: () _____
Title/Position: _____	Department: _____

Accident Location: _____
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:

Were you performing regular duties at the time of accident? Yes No
Did anyone see you get hurt? Yes No If yes, who? _____
Did you report this incident to anyone? Yes No If no, why not? _____
If yes, to whom did you report it?: _____ Title/Position: _____ When: _____
What time did you start work today? _____ am/pm. **What time was the injury?** _____ am/pm Unknown

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: _____
Provided by: _____
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. A copy of this form will serve as the original.

Employee Name (print): _____ **Employee Signature:** _____
Date (required): _____