

Bowling Green State University

Injury and Illness Report

Office Use Only
BGSU Log # _____

Instructions: This report must be submitted within 24 hours of occurrence. Please **PRINT** all information.
Call 911 for serious injuries or emergencies.

Submit to: Bowling Green Campus: Environmental Health and Safety, 102 College Park Office Building
 Bowling Green, Ohio 43403, Phone: (419)372-2171, Fax:(419)372-2194
Firelands Campus: Budget and Operations Office, 136 East Building, Huron, Ohio 44839
 Phone:(419)433-5560, Fax:(419)433-9696

Part 1: Employee Status (Check One)

Permanent Employee (full-time or part-time)	Temporary Employee (BGSU or Employment Agency)	Student Employee	Student	Visitor
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Part 2: Employee Information

Name (First, Middle, Last)		BGSU ID# (Social Security numbers are available to authorized agencies)		
Home Address (number and street, city or town, state, and zip code)				
Home Phone ()	Campus Phone ()	Date of Birth	Male Female	
Department		Position or Title	Date of Hire	

Part 3: Incident Information

Date <u>AND</u> time of injury, exposure Check if time can not be determined	Time employee began work _____AM _____PM	Was the injury, illness, or exposure on BGSU property? Yes No		
Location of injury or illness (use building name if applicable)	Was the injury/illness job related? Yes No	Did it occur during overtime? Yes No		
Was there property damage? Yes * No *If Yes, please describe:				
Injury or Illness Classification:				
Animal bite or sting	Assault	Heat Burn	Chemical Burn	
Chemical Irritation	Cut	Electrical Shock	Foreign object in eye	
Infection	Repetitive motion	Slip, trip or fall	Strain or sprain	
Struck by an object	Exposure to blood	Other (explain): _____		
What is the nature of the injury or illness and the <u>specific</u> body parts affected? (For example: cut on the left thumb or sprain in the right ankle).			Did the injury result in death? Yes No Date of Death _____	
What happened? Describe how the injury or illness occurred (the work activity and the objects, equipment or substances involved).				

Part 4: Witness(es) (Attach additional sheet if needed)

Names, addresses and phone numbers:	
Report prepared by:	Date of report:
Position/Title:	Phone:

Bowling Green State University Injury and Illness Follow-Up Report

Instructions: This follow-up report applies to **BGSU employees only**. Department supervisors or managers must submit this follow-up report.

If not completed at the time of the injury and illness report, this follow-up report must be delivered or faxed to Environmental Health and Safety (Bowling Green Campus) or to the Budget and Operations Office (Firelands Campus) within **5 calendar days** of the date of the injury or illness. If sent separately, give the following information on the injured or ill employee:

Name:	Date of Injury/Illness:
Injury or Illness (brief description):	

1. Detailed Incident Description

What equipment, object or substance directly injured the employee? (ie. concrete floor, radial arm saw, specific chemical)

What was the employee doing just before the incident occurred? Describe the activity including tools, equipment and material used.

2. Medical Treatment (Complete As Applicable)

Was the employee treated in an emergency room? Yes No	Was the employee hospitalized overnight as and in-patient? Yes No
Name of Hospital or Urgent Care Center:	Phone Number: ()
Treating Physician or Registered Professional:	Phone Number: ()
Address(es) of Treating Physician or Registered Professional (number and street, city or town, state, and zip code)	
Description of Treatment (first aid treatment, treatment of infection, sutures, prescription medications, etc.):	

3. Did the Injury or Illness lead to any of the following situations?

Days away from work? (number of **calendar** days lost, starting with the day after the injury)
Yes No If Yes, list the number of lost work days: _____

Restricted workdays? (number of **calendar** days, starting the day after the injury, the employee remained at work and the employer or health care professional recommended keeping the employee from performing the routine functions of his or her job or from working the full work day)
Yes No If Yes, list the number of restricted work days: _____

Transfer to another job?
Yes No

Report Prepared By:	Date of Follow up Report:
Position/Title:	Phone:
Employee Signature:	Supervisor Signature:
I certify that the above information is accurate to the best of my knowledge. By signing this form, I agree to the disclosure of my health information and authorize my medical providers to release information to Bowling Green State University and its representatives.	