Employee Accident/Injury Report

Employee Information:

Name: _____

Home Address: _____

Department: _____ Job Title: _____

Accident/Injury Information:

Date of Accident/Injury: _____ Time of Accident/Injury: _____

Being as detailed as possible, describe the injury and what the employee was doing when the accident/injury occurred. Describe the activity as well as any tools, equipment or materials being used at the time.

Being as detailed as possible, describe the affected part(s) of the body and how those part(s) were affected (example: lower back strain).

Please print or type.

List the provider(s) you are authorizing to release medical records in the space indicated on this form.
Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name	Employer MCO or QHP		

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here **(Community Mercy Occupational Health & Medicine, Springfield Regional Hospital, PLEASE LIST OTHERS AS NEEDED)** that attend or examine