Oregon State UNIVERSITY OSU Office of Human Resources, Employee Benefits, &$(Kerr Administration Building, (541) 737-&, $)

Report of Accident/Illness Form Instructions

Form to be completed by:

- ***Immediate supervisor for employee injuries***
- ***OSU employee notified of any injury to non-employees***

The following list provides more detail on information to be completed on the OSU report of Accident form:

Accident Location: Give exact location including: room number, building or shop name. If accident occurred outside, list the nearest building and/or buildings. Refer to roads and places by exact names.

Brief Accident Description: In your opinion, explain in detail how the accident occurred.

List Witnesses (include contact information): Persons that actually witnessed the accident.

When was the accident reported to University: If employee accident is not reported within 24 hours of the accident, investigate why it was not reported. Remind employees that all accidents are to be reported immediately to their supervisor and no later than 24 hours after the accident.

Equipment or materials involved in accident: If the accident involved faulty equipment, describe what equipment was involved and what happened to the equipment. If the manufacturer is at fault, claims costs may be recovered and OSU would not be required to pay. *Save the faulty equipment*.

Was the accident caused by another person not employed by OSU? In your opinion, was another individual, other than an OSU employee, responsible for the accident? If so, there could be a third party claim and claims costs may be recovered from the responsible party.

Describe injury: Be very specific about the injury, including the body part injured (for example: left thumb, right ankle, etc…) and the type of injury (for example: cut, contusion, fracture, strain, sprain, insect or animal bite, burn, puncture, eye injury, unconsciousness, dizziness, etc…).

Describe first aid or medical treatment (when; by whom)? What type of medical treatment or first aid did the injured person receive and who performed the treatment.

Corrective Action: What issues can be addressed to minimize the chance that this accident would occur again (safety hazard in area to be addressed, possible training for employee, safety measures not taken by employee, etc…).

Is this a job related injury: Mark the “yes”, “no”, or “unknown” box. Answer yes if you have first hand knowledge that the injury was caused by work. If it is not apparent that the injury occurred while the employee was performing his/her duties, check “unknown”. Check “no” if you are certain the injury or illness did not occur during the course or scope of employment.

NOTE: If an employee sought medical attention from a professional (doctor, nurse, urgent care, or other medical facility), then a SAIF 801 form must be completed within 24 hours of the treatment. *If the employee is unavailable to complete the form, the supervisor is responsible for completing the employer section and as much as possible of the worker section of the form and submitting it by fax the Office of Human Resources within 24 hours.*

Work location: For employees – which OSU location does the person work from, if marking “other”, please specify department and location (for example, specific extension office).

Online Form available at http://oregonstate.edu/admin/hr/benefits/roa.pdf

E-mail completed form to heidi.melton@oregonstate.edu within 24 hours of accident.

Revised: 06/09/2011

Report of Accident/Illness Form

- Employee accidents: immediate Supervisor completes this form immediately.
- Non-employee accidents: OSU employee notified of injury completes this form.
- Click the “Submit by Email” box at the bottom of the completed form to submit to the Office of Human Resources (please note, should be completed and submitted within 24 hours of Accident). Next, print a copy of the completed form for your department records.

Please designate person’s status (check one field below):

☐ Faculty/Staff ☐ Contractor ☐ Temporary Employee (paid by OSU) ☐ Volunteer
☐ Student Worker ☐ Student ☐ Temporary Employee (paid by temp agency) ☐ Visitor
☐ Other (specify): ____________________

Name of Injured:			
Address (Street, City, State, Zip):			
Home Phone:		Cell/Alternate Phone:	
Date of Accident:		Accident Location:	
Brief Accident Description:			
List Witnesses (include contact information):			
When was accident reported to University:			
Equipment or materials involved in accident:			
Was the accident caused by another person not employed by OSU? ☐ Yes ☐ No			
If yes, list name and phone number:			
Describe Injury (body part & injury type):			
Describe first aid or medical treatment (when; by whom?)			
Completed by (please print):			
Work Number:		Title:	
Corrective Action (to be completed for all reports):		Report Date:	
Below section for <u>employee</u> accidents only, not required for non-employee reports. Please provide additional employee information below.			
NOTE: *if medical attention sought for **employee’s** job related injury, SAIF 801 form required within 24 hours*			
University ID #:		Is this a job related injury? ☐ Yes ☐ No ☐ Unknown	
Job Title:			
Department:			
Work Location: ☐ OSU Main ☐ OSU Cascades ☐ HMSC ☐ Other (specify)			