Injured Worker's Report of Workplace Accident

Part A must be filled out by the injured worker and submitted to the injured worker's immediate supervisor **immediately** after a workplace injury. **Part B** must be filled out by the injured worker if the worker has or will be filing a claim for Ohio Workers' Compensation benefits. This form shall be forwarded by the Division along with the completed OWC-4 form to the Office of Risk Management **immediately** following the injury. Attach additional sheets if necessary. Please write clearly. Failure to complete the entire form in a timely manner is a violation of City policy and may result in discipline.

PART A: INJURED WORKER'S INFORMATION

Injured Worker's Name:			Social Security Number:
Home Address:			Home/Cell Phone No:
Job Title:	Department:		Division:
Date of Injury:	Date of Hire:		Time of Injury:
Did injury occur on City property? : ☐ Yes ☐ No	Address of work site where injury occurred:		
What were you doing at the time of the injury? :			
Name of witnesses:			
Describe how injury occurred:			
What equipment/tools were you using? :			
Did you continue working after the injury?: ☐ Yes ☐ No			

Nature and extent of your injury. Check boxes and lines below to indicate which body parts were affected:

☐ Abdomen / Stomach	☐ Face	☐ Leg (Upper – above knee) (__ Right / __ Left)
☐ Ankle (__ Right / __ Left)	☐ Finger(s) - Which hand? ☐ Right ☐ Left	☐ Mouth
☐ Arm (Lower – below elbow) (__ Right / __ Left)	__ 1st (Thumb)/ __ 2nd (Index) /__ 3rd / __ 4th / __ 5th	☐ Neck
☐ Arm (Upper – above elbow) (__ Right / __ Left)	☐ Foot (__Right / __ Left)	☐ Nose
☐ Back: __ Upper / __ Mid / __ Low	☐ Hand (__ Right / __ Left)	☐ Ribs
☐ Buttocks	☐ Head	☐ Scalp / Skin (Specify location below)
☐ Chest	☐ Hip / Pelvis (__ Right / __ Left)	☐ Shoulder (__ Right / __ Left)
☐ Ear (__ Right / __ Left)	☐ Jaw	☐ Toe(s) - Which Foot? ☐ Right ☐ Left
☐ Elbow (__ Right / __ Left)	☐ Knee (__ Right / __ Left)	__ 1st (Big Toe) __ 2nd / __ 3rd / __ 4th / __ 5th
☐ Eye (__ Right / __ Left)	☐ Leg (Lower – below knee) (__ Right / __ Left)	☐ Wrist (__ Right / __ Left)

Other body part or further explanation of injury:		
Has the body part(s) listed been previously injured?		
Who did you report the injury to? :		Date and time reported:
Did you seek medical treatment? : ☐ Yes ☐ No	If yes, when and where:	

Employee's Signature: _____ Date Submitted: _____

Immediate Supervisor's Signature: _____ Date Received: _____

PART B: INJURED WORKER'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This section to be filled out only if the injured employee has filed or will file a workers' compensation claim.

As provided in Section 4123.651(C) of the Ohio Revised Code, I hereby authorize the release to the Industrial Commission of Ohio, the Ohio Bureau of Workers' Compensation, my employer the City of Cleveland, and their representatives, including legal counsel, of medical information, records, and reports necessary to the administration of my workers' compensation claim, as such medical information, records, and reports may pertain to a condition either allowed or alleged in my claim, or to determine the eligibility for payment of compensation and medical benefits in my workers' compensation claim. A photo static copy of this release shall have the same effect as the original.

Employee's Signature: _____ Date: _____

Physician's Name: _____ Physician's Phone Number: (____)_____

Physician's Address: _____

Street City/State Zip Code