WORKERS' COMPENSATION INCIDENT REPORT

ASSOCIATED COMPENSATION RESOURCES (ACR) FAX: 216-731-8290

☐ NOTE: Place a check here if this is an occupational (work related) accident.

ACCIDENT - INCIDENT - INJURY - ILLNESS INVESTIGATION REPORT*

Part I (Complete ALL sections of form. Enter "N/A" if not applicable. Do not leave any blank areas.
EMPLOYER: Supervisors MUST *complete shaded* ☐ *areas.)*

Type of Incident:

Date of this Report:	Unit/Location:	Report No.

1. Name of Diocesan Facility:

2. Mail address *(No. and street, City or town, State, and zip code)*

3. Location, if different from mail address

INJURED OR ILL EMPLOYEE/PERSON (COMPLAINANT/VICTIM/SUSPECT)

4. Name (FIRST) (MIDDLE) (LAST) — Social Security No.: - -

5. Home Address (No. & Street) (City/Town) (State) (Zip Code)

5a. Phone Number: Residence / Business	6. Age:	7. Sex: M F (Circle One)

8a. Occupation (Enter regular job title, note the specific activity he/she was performing at the time of injury)

8b. Is this person working at his/her regular job? yes ____ no ____	Sent home? yes ____ no ____	Hospitalized? yes ____ no ____

9. Dept. Number.	9a. Department name (Enter name of department or division in which the injured person is employed, even though they may have been temporarily working in another department at the time of injury)

10. Place of Accident or Exposure (No. and street, City or town, State and Zip code)
(Give exact location)

11. Was place of accident or exposure on employer's premises? ☐ Yes ☐ No	Witness or Fellow Employee:

Witness or fellow employee Dept./Address/Phone Number:

DESCRIPTION OF ACCIDENT/INCIDENT

12. What was person doing? (Be specific. Include tools, machine and materials used.) Name them, and what employee was doing with them)

13. How accident/incident occurred ? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

14. Describe the nature of injury or illness in detail and indicate the part(s) of the body affected. (e.g. amputation of right index finger at second joint, fracture of ribs, lead poisoning, dermatitis of left hand, etc.)

_____

_____

15. Name the object or substance which directly injured the employee. (For example, the machine or thing he/she struck against or which struck him/her; the vapor or poison he/she inhaled or swallowed; the chemical or radiation which irritated his/her skin; or in cases of strains, hernias, etc., the thing he/she was lifting, pulling, etc.)

16a. Date of Accident/Illness/Incident or initial diagnosis of occupational illness. _____

16b. Time _____ | 16c. Date/Time Employee Returned to Work _____ | 17. Did employee die? (Check one) Yes __ No __

18. Attending Physician: (Full name, Medical License) _____

_____

Identify Medical title MD/DO/D.O.C., etc.)

Office Address _____

Other Para-Medical: (Identify, Name, Address, etc.) _____

19. Transported to Hospital/Clinic? yes _____ no _____ _____

(If yes, note agency)

Hospital/Clinic: (Identify, Address) _____

_____

Part II

Identify all damaged equipment or property by name, type, model, etc.	EQUIPMENT OR PROPERTY DAMAGED Ownership	LOST/FOUND/STOLEN Estimate of Damages (labor and parts)

Incident Reported by:	Report Prepared by:
Address: _____	Phone:
_____	_____
_____	Signature, Title

Reviewed by Safety Representative _____

(Signature)

Distribution:	Status: { } open { } closed Date:
_____	NOTE: Determine if this incident/accident should be reported to respective insurance company.
_____	[ ] yes [ ] no Date Reported _____
_____	

*This report does not include every loss potential, but relates only to the potential hazards, and conditions examined and described in this report. It does not include violations of any federal, state or local statute, ordinance or regulation since we have made no judgment whether or not such violation exists. NOTE: Part One of this form is meant to meet the recordkeeping requirements of the OSHA Form No. 101, Bureau of Labor Statistics Supplementary Record of Occupational Injuries and Illnesses. Maintain this report in the establishment for a minimum of five (5) years.