HUNTER CONSULTING COMPANY

6600 Clough Pike
Cincinnati, OH 45244

CATHOLIC DIOCESE OF COLUMBUS – SELF-INSURED RISK NUMBER 20003224

INITIAL REPORT ON WORK-RELATED INJURY OR ILLNESS

1. Has a fatality occurred? ☐ No ☐ Yes If yes, date of death (mo./day/yr.) _____ /_____ /_____

2. Employee Name (last, first, middle) _____

3. Date of Birth (mo./day/yr.) _____ /_____ /_____

4. Soc. Sec. # _____ - _____ - _____

5. ☐ Female ☐ Male

6. Home Address (# and street, city, state, and zip code)_____

7. Home Phone (____) _____ - _____

8. Other Phone (____) _____ - _____

9. Date Hired (mo./day/yr.) _____ /_____ /_____

10. Job Title _____

11. Department _____

12. Dept. Phone (____) _____ - _____

13. Date of injury or illness (mo./day/yr.) _____ /_____ /_____

14. Time of injury or illness: ☐ am ☐ pm

15. Was employee on duty at the time? ☐ Yes ☐ No

16. Is this a new injury or illness? ☐ Yes ☐ No

17. Location of Incident (address, if known)_____

_____

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18. Name(s) and Phone(s) of Witness(es) _____ or ☐ No Witnesses

19. Name of Supervisor Notified _____ Date & Time Notified _____

20. Did employee receive medical treatment following this incident? ☐ Yes ☐ No

21. Medical Facility (name, phone, address) Date of Treatment _____

_____

22. Name of medical provider/physician: _____

23. Was employee treated in an emergency room? ☐ Yes ☐ No

24. Was employee hospitalized overnight as an in-patient? ☐ Yes ☐ No

25. Check Part(s) of Body Affected and circle Right/Left or both

☐ Head (R / L)	☐ Face and Neck (R / L)	☐ Eye (R / L)	☐ Chest/Abdomen (R / L)
☐ Arm (R / L)	☐ Hand (R / L)	☐ Leg (R / L)	☐ Foot (R / L)
☐ Upper Back (R / L)	☐ Middle Back (R / L)	☐ Lower Back (R / L)	☐ Other (R / L)_____

26. Check Specific Type of Injury or Illness

☐ Fracture	☐ Foreign Body	☐ Bruise	☐ Cut/Scrape
☐ Burn	☐ Sprain or Strain	☐ Other _____	

27. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials; "spraying chlorine from hand sprayer"; "daily computer key entry."

_____

_____

28. What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

_____

_____

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29. What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

_____

30. Who completed this form? ☐ Injured employee ☐ Supervisor Other _____

31. Date completed _____

I certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. Furthermore, I understand the information I supplied may be audited by the Company or its representatives. I understand that falsifying this document may be grounds for disciplinary action up to and including termination of employment. In addition, I may be in violation of Federal and/or State laws and subject to prosecution.

32. Employee's Signature _____ Date _____

I have reviewed this report and acknowledge its receipt.

33. Supervisor's Signature _____ Date _____

MAIL THIS FORM TO THE ADDRESS ABOVE, FAX TO 513-372-8748, OR EMAIL TO abehrend@hunterconsulting.com