State of Ohio — Public Employment Risk Reduction Program — Form 301P (Rev. 01/2015)

Injury and Illness Incident Report

ATTENTION: This form contains information relating to employee health. Please use it in a manner that protects the confidentiality of employees while also allowing for use of the information for occupational safety and health purposes.

Ohio Bureau of Workers' Compensation
Division of Safety & Hygiene, PERRP
13430 Yarmouth Dr., Pickerington, OH 43147

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness occurs. Together with the *Log of Work-Related injuries and Illnesses* (300P) and the accompanying Summary (300AP), these forms help you and PERRP develop a picture of the extent and severity of work-related incidents. You must complete this form or an equivalent ***within six calendar days*** after receiving information that a recordable work-related injury or illness has occurred.

BWC's *First Report of an Injury, Occupational Disease or Death* (FROI) is an acceptable substitute. To be considered an equivalent, the substitute must contain all of the information on this form. You must keep this form on file for five years following the year to which it pertains.

If you need additional copies of this form, you may photocopy (or print) and use as many as you need.

ATTENTION: All **Ohio public employers** must complete this form (or an equivalent). This includes the State of Ohio and its instrumentalities; and "any political subdivisions and their instrumentalities, including any county, county or state hospital, municipal corporation, city, village, township, park district, school district, state institutions of higher learning, public or special district, state agency, authority, commission or board" as defined in Ohio Revised Code 4167.01.

Completed by _____

Title _____

Phone _____ Date _____

Information about the employee

1) Full name _____

2) Street _____

City _____ State _____ Zip code _____

3) Date of birth _____

4) Date hired _____

5) Job title _____

6) ☐ Male ☐ Female

Information about the physician or other health-care professional

7) Name of physician, other health-care professional or first-aid provider

_____

8) If treatment was given away from the work site, where was it given?

Facility _____

Street _____

City _____ State _____ Zip code _____

9) Was employee treated in an emergency room?
☐ Yes ☐ No

10) Was employee hospitalized overnight as an in-patient?
☐ Yes ☐ No

11) Did the employee receive treatment classified as first aid at the work site or hospital?
☐ Yes ☐ No

Information about the case

12) Case number from the Log _____ (Transfer the case number from the Log after you record the case.)

13) Date of injury or illness _____

14) Time employee began work _____ (AM/PM)

15) Time of event _____ (AM/PM) ☐ Check if time cannot be determined.

16) **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.)

17) **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.)

18) **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected; be more specific than just using the words "hurt," "pain" or "sore." (Examples: strained lower back; chemical burn, right hand; carpal tunnel syndrome, left wrist.)

19) **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.

20) **If the employee died, when did death occur?** Date of death _____