11083 Hamilton Avenue
Cincinnati, OH 45231-1499
513.674.4364

The Center for Collaborative Solutions Comprehensive Substitute Solutions
Accident/Exposure Incident Reporting Procedure

The Center for Collaborative Solutions Council of Governments is committed to the safety and health of our employees. In the event, however, that you are involved in an accident and/or suffer an injury while engaged in a job-related activity, you must perform the following steps:

1. **Seek prompt medical treatment or first aid** (even when the resulting injury appears minor). If you suspect possible exposure to blood borne pathogens, go immediately (within 24 hours) to BethesdaCare for evaluation/treatment. See additional information below.
2. **Immediately report the incident** to the following:
   a. CCS-COG Substitute Services Administator – Tom Collins at 513-674-4264 **AND**
   b. HCESC Human Resources - Karen Monroe at 513-674-4243 **AND**
   c. The designated school district administrator.
3. **Complete and submit an Accident/Exposure Incident Report within 24 hours** of the incident
   a. You must "Save" a copy of this document before you fill it out!
   b. Complete all required fields.
   c. Print out the form, sign and date it.
   d. Fax to HCESC Human Resources - Karen Monroe 513-674-4206. Keep a copy for your records.

If there has been a possible exposure to blood borne pathogens, immediate action is necessary. You should go to a BethesdaCare location within 24 hours of possible exposure for medical evaluation/treatment. All indicated treatment and follow-up will be provided by BethesdaCare. You may go to one of the following locations:

BethesdaCare Blue Ash	11125 Kenwood Rd.	791-4040
BethesdaCare Norwood	4592 Montgomery Rd.	731-3399
BethesdaCare Queensgate	1150 W 8th, Suite 120	241-4135
BethesdaCare Sharonville	3801 Hauck Rd.	563-1505
BethesdaCare Eastgate	4452 Eastgate Blvd	752-3695
BethesdaCare Arrow Springs	100 Arrow Springs Blvd.	282-7075
Good Samaritan Occupational Medicine Center	375 Dixmyth Avenue	872-2875

Human Resources will be in contact with you to oversee post-exposure and/or post-accident follow-up procedures.

The CCS-COG conducts investigations into all accidents and exposure incidents. Each investigation will be conducted in conjunction with the Substitute Services Administrator and may include on-site inspections, securing statements from witnesses, contact with medical providers and/or other investigatory measures as deemed appropriate for the specific incident.

NOTE: All medical records and those related to worker's compensation are kept separate from your personnel file and are considered confidential. No medical record or part of a medical record will be disclosed without the written consent of the employee or as required by law.

Exposure Control Plan:
The Center for Collaborative Solutions has an Exposure Control Plan for Blood borne Pathogens. This document is designed to protect our employees from possible infection caused by contact with blood borne pathogens as a result of performing job duties. It includes Universal Precautions and addresses the issue of Personal Protective Equipment. In addition, it serves as a resource for our staff in understanding the medical evaluation and follow-up procedure for a possible exposure to blood borne pathogens. Employees identified as working in a job classification with potential risk for occupational exposure have been provided with an overview of this document and may obtain their own copy upon request.

Worker's Compensation:
To initiate a Worker's Compensation Claim, call 1-888-247-7799 to report your injury and provide them with the CCS-COG's risk number - 1656046-0.

11083 Hamilton Avenue
Cincinnati, OH 45231-1499
513.674.4364

CENTER FOR COLLABORATIVE SOLUTIONS ACCIDENT/EXPOSURE INCIDENT REPORT

****** Must be completed within 24 hours of incident ******

If you seek medical care, you must call 1-888-247-7799 to report your injury.
The CCS-COG's Risk Number is 1656046-0.

Important Directions for Completing this Report:

1. You must "Save" a copy of this document before you fill it out!
2. Complete all required fields.
3. Print out the form, sign and date it.
4. Fax to HCESC Human Resources - Karen Monroe 513-674-4206. Keep a copy for your records.

Date of Report: **Time of Report:** ☐ AM ☐ PM

First Name: **Last Name:**

Home Address:
Street:
City: State: Zip Code:

Title / Position: **Home Phone:**

Work location at time of incident: **Work Phone:**

Date of Incident: **Time of Incident:** ☐ AM ☐ PM

Date of Initial Incident Notification: **Time of Initial Incident Notification:** ☐ AM ☐ PM

Who did you notify of the incident?
☐ **I notified the Substitute Services Administrator, Tom Collins at 513-674-4264.**
☐ **I notified HCESC Human Resources. Who did you speak with in HR?**
☐ **I notified the School/District. Who did you speak with at the School?**

What job duties were you performing when incident occurred?

Describe the incident:

What body part(s) were injured?

☐ Abdomen	☐ Chest	☐ Face	☐ Hand	☐ Leg	☐ Ribs	☐ Toe
☐ Ankle	☐ Ear	☐ Finger	☐ Head	☐ Mouth	☐ Scalp	☐ Wrist
☐ Arm	☐ Elbow	☐ Foot	☐ Hip	☐ Neck	☐ Shoulder	☐ Tooth
☐ Back	☐ Eye	☐ Groin	☐ Knee	☐ Nose	☐ Thigh	☐ Other:

What was the nature of the injury?

☐ Abrasion	☐ Bruise	☐ Burn	☐ Concussion	☐ Cut	☐ Dislocation	☐ Fracture
☐ Laceration	☐ Puncture	☐ Sprain	☐ Other:			

What object or substance directly injured you?

What personal protective equipment were you using at the time of the injury:

Did the PPE fail?
☐ **Yes** ☐ **No**

What first aid treatment was given:

Did you receive medical attention? ☐ **Yes** ☐ **No**
If yes, Physician's Name:

comprehensive substitute solutions

11083 Hamilton Avenue
Cincinnati, OH 45231-1499
513.674.4364

Address:
Phone:

Identify any witnesses to the incident.

Witness #1 Name: **Witness #1 Address:** **Witness #1 Phone:**	**Witness #2 Name:** **Witness #2 Address:** **Witness #2 Phone:**

As a result of this incident, are any of your normal work activities restricted? ☐ Yes ☐ No

If Yes, you must provide HCESC with a medical statement from your physician detailing the specific restrictions and duration of such restrictions. Fax to Human Resources at 513-674-4206.

As provided by Section 4123.651C of the Ohio Revised Code, I hereby permit the release of medical information, records and reports relative to the issues necessary for the administration of my workers' compensation claim to the Industrial Commission of Ohio, Ohio Bureau of Workers' Compensation, or the employer as such medical information, records and reports pertain to a condition either allowed or requested in my claim, or to consider the payment or to determine the eligibility of payment of compensation and medical benefits under my workers' compensation claim.

Employee's Signature: _____ **Date:** _____

ANSWER THE REMAINING QUESTIONS ONLY IF THE INCIDENT INVOLVED AN EXPOSURE

What body fluid(s) were you exposed to (blood or other potentially infectious material)?

What part(s) of your body were exposed:

☐ Abdomen	☐ Chest	☐ Face	☐ Hand	☐ Leg	☐ Ribs	☐ Toe
☐ Ankle	☐ Ear	☐ Finger	☐ Head	☐ Mouth	☐ Scalp	☐ Wrist
☐ Arm	☐ Elbow	☐ Foot	☐ Hip	☐ Neck	☐ Shoulder	☐ Tooth
☐ Back	☐ Eye	☐ Groin	☐ Knee	☐ Nose	☐ Thigh	☐ Other:

Did a foreign body (needle, nail, dental wire, etc.) penetrate your body? ☐ **Yes** ☐ **No**

Was any body fluid injected into your body? ☐ **Yes** ☐ **No** **If yes, how much?**

Name of source individual(s): Source #1: If source is a student, provide the name of parent/guardian of source individual(s): Source #2: If source is a student, provide the name of parent/guardian of source individual(s):	**Phone:** Source #1: Source #2:

Employee's Signature: _____ **Date:** _____

For Human Resources Use Only:

Date Received by Human Resources: _____
Date Investigation Initiated: _____
Date Investigation Completed: _____
Workers' Comp Claim Number, if appropriate: _____