For immediate access to The Center for Collaborative Solutions's Accident/Exposure Incident Report, click here.

Accident/Exposure Incident Reporting Procedure

The Center for Collaborative Solutions is committed to the safety and health of our employees. We make every effort to comply with relevant federal and state occupational health and safety laws and to develop the most feasible programs and procedures conducive to such an environment.

To this end, we have provided a set of expectations for our employees. We ask that you . . .

- Exercise maximum care and good judgment at all times to prevent accidents and injuries;
- Contact your supervisor and seek first aide for all injuries, regardless of how minor;
- Report unsafe conditions, equipment or practices to supervisory/administrative personnel;
- Use any safety equipment provided for your use; and,
- Conscientiously observe all safety rules and regulations at all times.

Employee Responsibility:

In the event 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 TriHealth for evaluation/treatment. See additional information below.
2. **Immediately report the incident** to the following:
    a. Dan Distel at 513-674-4264, and
    b. The designated school district administrator, if appropriate.
3. **Complete and submit an Accident/Exposure Incident Report within 24 hours** of the incident
    a. Open the Accident/Exposure Incident Report from www.SubSolutions.org
    b. "Save As" to where you want to keep your completed form.
    c. Complete all required fields.
    d. Print out the form, sign and date it.
    e. Email to dan.distel@hcesc.org. 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 TriHealth location within 24 hours of possible exposure for medical evaluation/treatment. All indicated treatment and follow-up will be provided by TriHealth. You may go to one of the following locations. TriHealth Occupational medicine Call Center for all locations is (513) 853-1040.

TriHealth Butler County	8500 Bilstein Boulevard, Hamilton, Ohio 45015
TriHealth Queensgate	1150 W 8th, Suite 120, Cincinnati, Ohio 45203
TriHealth Sharonville	3801 Hauck Rd., Cincinnati, Ohio, 45241
TriHealth Eastgate	4452 Eastgate Blvd, Suite 101, Cincinnati, Ohio 45245
TriHealth Arrow Springs	100 Arrow Springs Blvd., Lebanon, Ohio 45026

Human Resources Responsibility:

If there has been a possible exposure and/or a serious injury, your supervisor will have contacted Human Resources and provided preliminary information. Human Resources will be in contact with you and your supervisor to oversee post-exposure and/or post-accident follow-up procedures.

It is the responsibility of Human Resources to investigate all job-related injuries. The investigation will be conducted in conjunction with your supervisor 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.

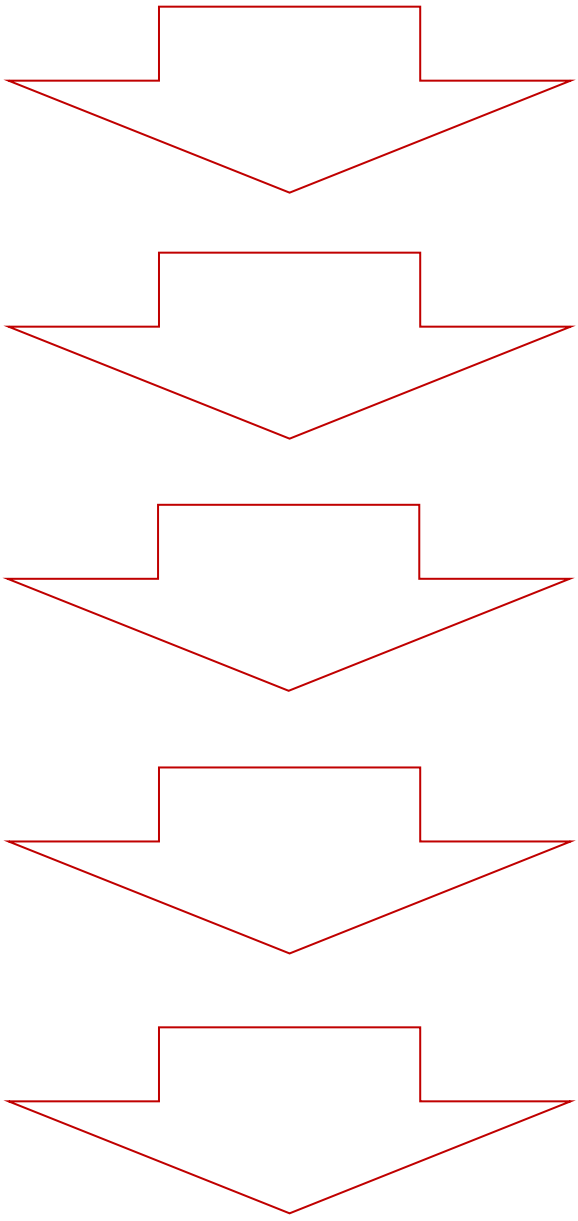
Exposure Control Plan:

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 request their own copy.

Worker's Compensation:
If you seek medical attention, you will be asked by the health care provider if you were “on the job” at the time of the injury. Most physicians or treatment centers will have Bureau of Worker’s Compensation forms. The Center for Collaborative Solutions must also have a completed Accident/Exposure Incident Report form.

To initiate a Worker’s Compensation Claim, call 1-888-247-7799 to report your injury and provide them with The Center for Collaborative Solutions risk number - #39316160-0.

After you have read the above procedures completely …
scroll down to access The Center for Collaborative Solutions’s Accident / Exposure Incident Form.



THE 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.
Use risk number #39316160-0 for The Center for Collaborative Solutions.

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. Email it to dan.distel@hcesc.org. Keep a copy for your records.

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

First Name: **Last Name:**

Home Address: (include street, city, state, and 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 my Supervisor. What is your Supervisor's Name?**
☐ **I notified Dan Distel, Sub Solutions Program Manager**
☐ **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:

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:**

Have you lost any workdays as a result of this injury? ☐ Yes ☐ No
If yes, specify dates of work loss:

If you have not yet returned to work, what is your estimated date of return:
Note: You must provide HCESC with a medical statement from your physician indicating the return to work date. Fax to Human Resources at 513-674-4206.

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: _____

OSHA300 Recordable Code(s): ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8**
1–Injury involving loss of consciousness
2–Injury involving restriction of work or lost time
days away from work = _____
days on restricted duty = _____
3–Injury involves transfer to another job
4–All work-related fatalities (deaths)
5–All work-related illness
6–All work-related injuries (treatment beyond first aid)
7-Not recordable
8-Human Bloodborne Pathogen Exposure