Franklin County
BOARD OF COMMISSIONERS
1803
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ACCIDENT REPORT FOR INJURED EMPLOYEES (ARFIE)

Injured Employee Information

		- -		/ /
Employee Full Name		**Social Security #**		**DOB (month/day/year)**
Home Street Address	**City**	**State**	**Zip Code**	**County**
Work Phone Number (including area code)		**Home/Cell Phone (including area code)**		**Male or Female**
Work email address		**Personal email address**		
				/ /
Agency Name		**Position Title**		**Date of Hire (month/day/year)**

Accident Information (to be completed by injured employee, or the supervisor in the event the employee is incapacitated)

1. **When did your work shift begin?** Date_____ Time_____am/pm
2. **When did the accident/injury occur?** Date_____ Time_____am/pm
3. **Did the accident/injury occur on County property?** Yes_____ No _____
4. **Where did the accident occur? (Be specific, i.e. address, floor, room #)**

5. **What were you doing just before the incident occurred?** *Describe the activity, as well as the tools, equipment or material you were using. Be specific. (Examples: climbing a ladder while carrying roofing materials; spraying chlorine from hand sprayer, daily computer key-entry.)*

6. **How did this happen?** *Tell us how the injury occurred. (Examples: when ladder slipped on wet floor, I fell 10 feet on my back; I was sprayed with chlorine in the eyes when gasket broke during replacement; I developed soreness in wrist from raking leaves.)*

7. **What was your 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 on right hand; carpal tunnel syndrome, left wrist)*

8. **What object or substance directly harmed you?** *(Examples: concrete floor; chlorine; radial arm saw) If this question does not apply to the incident, leave it blank.*

9. **Date accident/injury was reported to Supervisor:** Date_____ Time_____am/pm
10. **Supervisor's name or person accident was reported to:** _____
11. **Supervisor's work phone number (including area code):**_____

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12. Was Medical Treatment Sought? Yes_____ No _____

If yes, please provide the following medical provider information:

Medical Provider Name	**Name of Practice/Hospital/Urgent Care**	**Phone Number (including area code)**

Address	**City**	**State**	**Zip Code**	**County**

13. Were you treated in an emergency room? Yes _____ No _____

14. Did you receive treatment classified as beyond first aid at the hospital/medical facility? Yes _____ No _____

15. Were you admitted to the hospital for an overnight stay as an in –patient)? Yes _____ No _____

16. Was there a death, amputation, hospitalization, or loss of an eye as a result of your injury? Yes _____ No _____

If yes, please check all that apply:_____death,_____amputation,_____hospitalization,_____loss of eye

17. Were you injured as a result of an auto accident? Yes_____ No _____

If yes, please attach a copy of the motor vehicle accident report to this report, or send a copy of the report via fax to 614.525.5715 or via email to risk@franklincountyohio.gov when the report is available.

18. List the names of anyone who witnessed your accident/injury. Attached additional page(s) if necessary.

Witness #1_____ Witness #2 _____

Witness #3_____ Witness #4 _____

19. Employee Signature and Acknowledgement

I confirm that the information supplied on this form is accurate and truthful and that the accident/injuries described herein were not self-inflicted. I understand that the Franklin County Risk Management staff will investigate the circumstances of the events/accident related to my accident/injury. Further, I understand that I am applying for benefits under the Ohio Bureau of Workers' Compensation Act. I affirm that I elect to receive compensation and benefits under the Workers' Compensation Laws to which I am entitled and I waive my right to file for and receive compensation under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowed and I authorize direct payment(s) to my medical provider(s). I permit and authorize any provider who attends to, treats, or examines me to release medical, psychological, psychiatric, vocational, or social information that is casually or historically related to my physical or mental injuries relevant to the issues necessary for the administration of my claim to the Industrial Commission of Ohio, the Ohio Bureau of Workers' Compensation, the employer of record, and any employer authorized representatives. I understand that my previous or future Workers' Compensation claims may affect decisions made in this claim. I understand that proper administration of this claim may require parties to the claim to share this information for any and all such previous and/or future claims. The released claims information may include any record maintained in my claims files.

Employee Printed Name	**Employee Signature**	**Date**

Forward ARFIE to Supervisor/Management Representative for completion once pages 1 and 2 are completed.

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Supervisor Section

Please review pages 1 and 2 of the accident report as submitted by the employee. In the space please below provide relevant information such as additional details, comments and/or dispute of any or all of the injured employees' statements. Include details of the accident/injury as you saw it or as it was reported to you (noting who reported the accident to you).

1. **Was the injured employee able to return to work the same day the accident/injury occurred?** Yes _____ No _____ Don't know _____

2. **Did the injured employee complete page 1 and 2?** Yes_____ No _____

   If no, the employee's Supervisor should fill out pages 1 and 2 of this form to the best of their ability and explain why the employee was unable to complete pages 1 and 2. Please provide as much detail as possible.

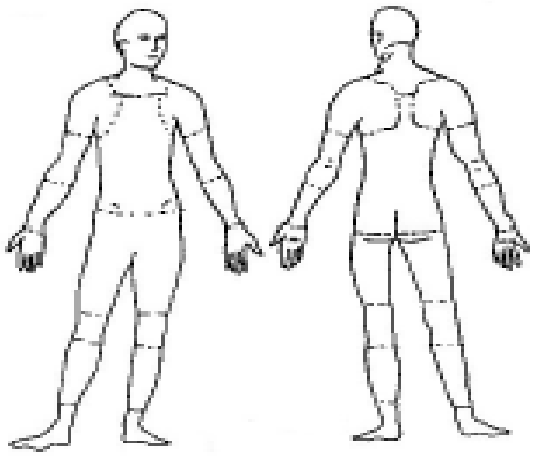
3. **Did the injury result in a death, amputation, hospitalization, or loss of an eye?** Yes _____ No _____

4. **What is the date of death if death occurred?** _____

IF YES, PLEASE REVIEW AND EXECUTE THE PROPER REPORTING PROCEDURE LISTED WITHIN THE INJURY PACKET IMMEDIATELY!

5. **Injured Employee (Complete this section for each injured employee)**

Part of Body affected: (shade all that apply)



Nature of injury: (most serious one)

- ☐ Abrasion, scrapes
- ☐ Amputation
- ☐ Broken bone
- ☐ Bruise
- ☐ Burn (heat)
- ☐ Burn (chemical)
- ☐ Concussion (to the head)
- ☐ Crushing Injury
- ☐ Cut, laceration, puncture
- ☐ Hernia
- ☐ Illness
- ☐ Sprain, strain
- ☐ Damage to a body system:
- ☐ Other _____

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6. How can future incidents be prevented:

What changes do you suggest to prevent this incident from happening again?

- ☐ Guard the Hazard
- ☐ Train the employee(s)
- ☐ Train the supervisor
- ☐ Redesign task steps
- ☐ Routinely inspect for the hazard
- ☐ Personal Protective Equipment
- ☐ Redesign work station
- ☐ Consideration of new policy/procedures
- ☐ Other: _____

Comments or suggestions: _____

_____

_____

7. List the names of additional witnesses to the accident/injury. Provide witness statement. See page 5 of ARFIE.

Witness #1_____ Witness #2 _____

Witness #3_____ Witness #4 _____

8. Supervisor's Certification and Signature

As supervisor or other management representative of the injured employee, I have reviewed this accident report and confirm that my statements are complete and truthful to the best of my knowledge.

Supervisor Printed Name **Supervisor Signature** **Date**

Please return completed ARFIE to Risk Management via email risk@franklincountyohio.gov or via fax to (614)525.5715

If you have questions or require additional information please call (614)525-4642 or (614) 525-6629

Case No. From PERRP Log:_____

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Witness Statement

- Name of injured employee: _____
- Name of witness: _____
- Location where incident occurred: _____
- Date of incident: _____ Time of incident: _____

1. What were you (the witness) doing at the time of the incident?

2. How and when did you become aware of the incident?

3. What did you hear at the time of the incident?

4. Describe what you saw at the time of the incident:

5. Who else was present?

6. Please relate any additional information you have pertaining to the incident:

Witness's signature: _____ Date signed: _____

Please return completed ARFIE to Risk Management via email risk@franklincountyohio.gov or via fax to (614) 525-5715. If you have questions or require additional information please call (614) 525-4642 or (614) 525-6629

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Authorization to Release Medical Records
And Disclose Professional and Personal Information

Employee Name		Social Security # - -		DOB (month/day/year) / /
Home Street Address	**City**	**State**	**Zip Code**	**Date of Injury (month/day/year) / /**

TO WHOM IT MAY CONCERN:

I hereby authorize you and/or any other hospital, medical institution, doctor or medical practitioner, insurance company, pharmacy, school board, employer, U.S. Defense Department, Veteran's Administration, Social Security Administration, or any agency of any state, county or municipality, or employee of any of the above or any provider who has given me medical and/or psychological treatment, to furnish and release to the Franklin County Board of Commissioners, or any of its authorized representatives or agents, any and all reports, records, files, and information pertaining to treatment of injuries sustained on date above.

This Authorization includes, but is not limited to, x-ray films, x-ray reports, pathology slides, tissue blocks, nurses' notes, diagnostic testing results, emergency room records and bills for services and applies from the past fifteen years from the date of this signed release to the present. This Authorization also applies to files and information regarding alcohol, drug and psychiatric/psychological reports, records, HIV test result, AIDS and AIDS related conditions. The sole purpose of this release is to further the administration of a workers' compensation claim(s) by my employer.

I waive and release the attached list of sources or facilities from any restriction imposed by law thereof, in disclosing any record, observation, diagnosis or communication to the Franklin County Commissioners or any of its authorized representatives or agents. I understand and agree that the information I have authorized to be released is exempt from the privacy requirements of the Health Information Portability and Accountability Act (HIPAA), pursuant to 45 CFR §164.512(e) and (l).

This Authorization is valid for five years from date hereof. I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. I understand that a copy of this Authorization shall serve in lieu of the original.

_____ _____

Date **Employee Signature**

Attention Medical Providers -- Please remit Medical records to:

Sedgwick, CMS
P.O. Box 14661
Lexington, KY 40512-4661
Fax 855-223-9836