ACCIDENT REPORT FOR INJURED EMPLOYEES (ARFIE)

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Injured Employee Information

Employee Full Name	*Social Security Number*	*DOB (Month / Day / Year)*

Home Street Address	*City*	*State*	*Zip Code*	*County*

Work Phone Number (Including Area Code)	*Personal Phone Number (Including Area Code)*	*Gender*

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:* _____
2. When did the accident/injury occur? *Date / Time:* _____
3. Did the accident/injury occur on County property? ☐ Yes ☐ No
4. Where did the accident occur? *(Be specific, i.e. address, floor, room number)*
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)*
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).*
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).*
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: _____
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 (Include 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. Attach additional page(s) if necessary.

Witness One: _____ (*Full Name* / *Phone Number*)

Witness Two: _____ (*Full Name* / *Phone Number*)

Witness Three: _____ (*Full Name* / *Phone Number*)

Witness Four: _____ (*Full Name* / *Phone Number*)

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:

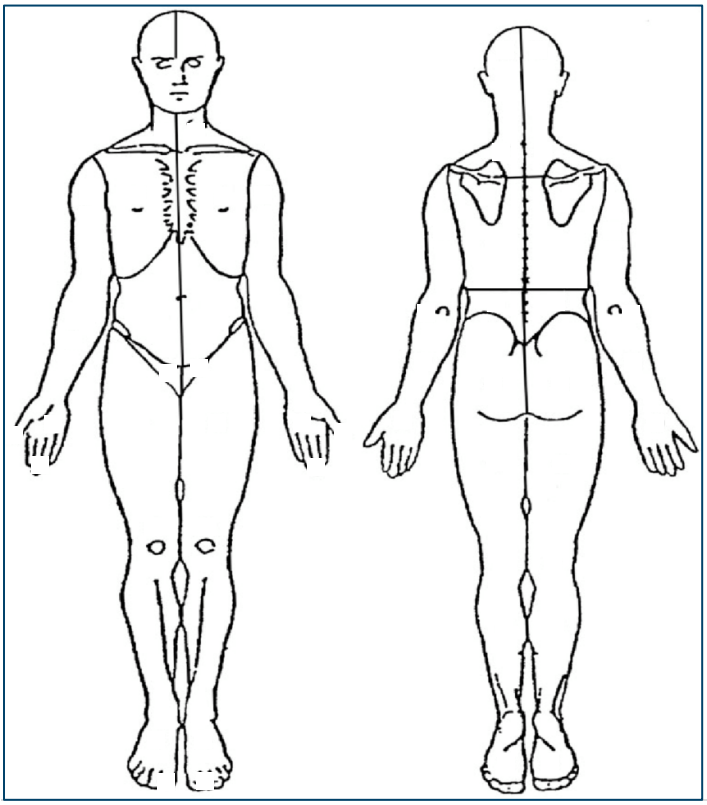
Please review pages 1 and 2 of the accident report as submitted by the employee. In the space below, please provide relevant information such as additional details, comments and/or dispute of any or all of the injured employees' statements. Include details of the accident/injury as you saw it or as it 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 ☐ Unknown
   If no, what was the last date employee worked? _____
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 the Body Affected (Shade all areas that apply)



Nature of Injury

☐	Abrasion (Scrapes)	☐	Fracture
☐	Acide Reflux	☐	Gunshot Wound
☐	Allergic Reaction	☐	Headache
☐	Amputation	☐	Hearing Loss
☐	Anxiety	☐	Hematoma
☐	Arthritis	☐	Hernia
☐	Blurred Vision	☐	Illness
☐	Burn - Chemical	☐	Inflammation
☐	Burn - Electrical	☐	Insomnia
☐	Burn - Heat	☐	Laceration
☐	Carpal Tunnel Syndrome	☐	Loss of Consciousness
☐	Chipped / Broken Tooth	☐	Memory Loss
☐	Closed Head Injury	☐	Multiple Physical Injuries
☐	Concussion	☐	No Physical Injury
☐	Contusion (Bruising)	☐	Other
☐	COVID-19	☐	Poisoning / Toxic Effects
☐	Crushing Injury	☐	Pre-Exhisiting Medical Condition
☐	Damage to a Bodily System	☐	PTSD
☐	Dehydration	☐	Puncture
☐	Dermatitis (Poison Ivy)	☐	Rupture
☐	Disease	☐	Sprain
☐	Dislocation	☐	Strain
☐	Dizziness	☐	Swelling
☐	Exposure to Foreign Bodily Fluid / Blood	☐	Tear
☐	Exposure to Unknown Substance	☐	Tendinitis
☐	Foreign Body in Eye	☐	Whiplash
☐	Unspecified Injury:		

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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(s)
☐ Redesign task steps	☐ Routinely Inspect for the Hazard	☐ Personal Protective Equipment
Redesign task steps	Consideration of new policy procedures	

☐ Other: _____

Comments or Suggestions:

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

Witness 5: _____ *Full Name* _____ *Phone Number*

Witness 6: _____ *Full Name* _____ *Phone Number*

Witness 7: _____ *Full Name* _____ *Phone Number*

Witness 8: _____ *Full Name* _____ *Phone Number*

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 & 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: _____

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