Coshocton County
Accident/Injury Report

Coshocton County
401 ½ Main Street
Coshocton, Ohio 43812-1586

Phone Number Direct: 740-295-7467
Phone Number – Commissioners: 740-622-1753
BWC Policy Number : 31600001-0

Injured or Ill Employee

First Name Middle Name Last Name		**Social Security No.**
Home Addresss (No. and Street, City, State, Zip)		**Home Phone:** **Work Phone:**
Date of Birth (m/d/y)	**Sex:** **Male ☐ Female ☐**	**Marital Status:** **Married ☐ Single ☐**
Occupation (job title or brief description)		
Department (enter name of department and/or division in which the injured person is regularly employed)		

The Accident or Exposure to Occupational Illness (use back if necessary)

If accident or exposure occurred on employer's premises, give address of plant or establishment in which it occurred. Do not indicate department or division within the plant or establishment. If accident occurred outside employer's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of injury as accurately as possible.

Place of accident or exposure (address):	**County:**	**Was place of accident or exposure on employer's premises?** **Yes ☐ No ☐**

What was the employee doing when injured? (Name any tools, material, or equipment, and tell what he was doing with them. Use back for additional space.)

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How did the accident occur? (Describe fully the events that resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how involved. Give full details on all factors that led or contributed to the accident. Use back for additional space.)

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Name(s) of Witness(es):

Describe the injury or illness in detail and indicate the part of body affected. (e.g. amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)

Name the object or substance which directly injured the employee. (For example, the machine or object he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his skin; or in cases of strains, hernias, etc., what he was lifting, pulling, etc.)

Date and Time of injury/disease: **AM** **/ / PM**	**Date Supervisor/Employer Notified:**	**Supervisor Signature and Date Received**

Other (use back if necessary)

Name and address of physician
If hospitalized, name and address of hospital

Medical Release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to my employer, my employer's managed care organization or to my employer's representative, CompManagement Inc./Sedgwick CMS. A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ **Date (required)**_____