U.S. Department of Labor
Bureau of Labor Statistics
Supplementary Record of
Occupational Injuries and Illnesses

Report of Injury or Accident Involving Employees

Reading Community Schools
1301 Bonnell Avenue
Reading, Ohio 45215

This form is required by Public Law 91-596 and must be kept in the establishment for *5 years.* Failure to maintain can result in the issuance of citations and assessment of penalties.

Case or File No.

Form Approved
O.M.B. No. 1220-0029

See OMB Disclosure Statement on reverse.

Employer

1. Name

2. Mail address *(No. and street, city or town, State, and zip code)*

3. Location, if different from mail address

Injured or Ill Employee

4. Name *(First, middle, and last)* | Social Security No.

5. Home address *(No. and street, city or town, State, and zip code)*

6. Age | 7. Sex: *(Check one)* Male ☐ Female ☐

8. Occupation *(Enter regular job title, not the specific activity he was performing at time of injury.)*

9. Department *(Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)*

The Accident or Exposure to Occupational Illness

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.

10. Place of accident or exposure *(No. and street, city or town, State, and zip code)*

11. Was place of accident or exposure on employer's premises? Yes ☐ No ☐

12. What was the employee doing when injured? *(Be specific. If he was using tools or equipment or handling material, name them and tell what he was doing with them.)*

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

Occupational Injury or Occupational Illness

14. 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.)*

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

16. Date of injury or initial diagnosis of occupational illness | 17. Did employee die? *(Check one)* Yes ☐ No ☐

Other

18. Name and address of physician

19. If hospitalized, name and address of hospital

Date of report	Prepared by	Official position

OSHA No. 101

White - Treasurer • Yellow - Building Principal • Pink - Clinic • Goldenrod - Assistant Superintendent