

**FORM A**  
**MEDINA COUNTY EMPLOYEE**  
**ACCIDENT, INJURY & ILLNESS REPORT**  
*(TO BE COMPLETED BY THE EMPLOYEE)*  
**PLEASE PRINT IN INK OR TYPE**

Name of injured person \_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
City/State/Zip \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
Job Title \_\_\_\_\_ Department \_\_\_\_\_  
Supervisor \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

- 1) Date of injury or onset of symptoms \_\_\_\_\_ Time \_\_\_\_\_ AM PM
- 2) Describe the injury and what caused the injury/symptoms. Please be specific. Also note what you were doing just **BEFORE** the incident, and what you did **AFTER** the incident *(If you need more space, write on the back of this form)*. **Be specific - name any objects, substances, vehicles or equipment that may have been involved.**  
\_\_\_\_\_  
\_\_\_\_\_
- 3) Did you report this incident to anyone?  YES  NO If NO, why not? \_\_\_\_\_
- 4) If YES, to whom did you report it? \_\_\_\_\_ Title \_\_\_\_\_
- 5) Did anyone else see what happened?  YES  NO If YES, Who? \_\_\_\_\_
- 6) What part(s) of your body was/were affected? *(Be specific; i.e., left elbow, right knee, etc.)* \_\_\_\_\_  
\_\_\_\_\_
- 7) What type of injury did you experience? *(Be specific; i.e., bruise, scrape, laceration, pull, etc.)* \_\_\_\_\_
- 8) Was any type of first aid provided at the scene?  YES  NO If YES, describe \_\_\_\_\_
- 9) Who provided first aid? \_\_\_\_\_
- 10) Did you seek other medical treatment?  YES  NO Where? \_\_\_\_\_  
When? \_\_\_\_\_ If treatment was not sought immediately, explain why: \_\_\_\_\_  
\_\_\_\_\_
- 11) Was there lost work time due to injury?  YES  NO Date lost work began \_\_\_\_\_ Total # of days of lost work (est.) \_\_\_\_\_
- 12) Is this an aggravation of a previous injury/symptom?  YES  No If YES, when were you last treated for the previous injury? \_\_\_\_\_  
By Whom? \_\_\_\_\_
- 13) Have you ever had a similar injury?  YES  NO If yes, describe the other injury \_\_\_\_\_
- 14) What was the length of time between the onset of your symptoms and your disability? \_\_\_\_\_
- 15) Date of diagnosis or first treatment for this condition \_\_\_\_\_ Current Diagnosis \_\_\_\_\_
- 16) Medical visits during the last five years: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 17) Current medications prescribed by your doctor (s); include doctor's name \_\_\_\_\_  
\_\_\_\_\_

**EMPLOYEE SIGNATURE**

Printed Name of Employee \_\_\_\_\_ Employee Signature \_\_\_\_\_

Date *(required)* \_\_\_\_\_