AIM LEASING COMPANY EMPLOYEE INJURY REPORT (OHIO ONLY)

Associate Information: (To be completed by Employee)

First Name: ____________________________ Middle Initial: ______ Last Name: _______________________________________

Street Address: ______________________________________ City ___________________________________ Zip Code___________

Home Telephone Number: _________________________ Soc. Security Number: ________________________ Assoc. No. __________

Birth Date: _____________Age: ______ Hire Date: __________ Supervisor Name: _______________________________________

Shift: ___________ Department: ______________________ Job Title: ____

Accident Information: (To be completed by Employee)

Date of Accident: ___________________ Time: _____________ AM/PM Day of Week: ____________________________________

Exact Location of Accident: ____
(Department Name, Building Name, Location in Building, etc.)

Description of how accident occurred: ____

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Witnesses: ____

Did you seek medical treatment? [] Yes [] No If yes, where did you seek treatment ________________________________

Were X-rays taken? [] Yes [] No Did you receive a prescription? [] Yes [] No

Has physical or occupational therapy been ordered? [] Yes [] No

Were there any days that you were unable to work as a result of the accident? [] Yes [] No
If yes, dates involved: From ___________________ to ____________________

Were there any days that you were restricted as a result of the accident? [] Yes [] No
If yes, dates involved: From ___________________ to ____________________

How many hours do you normally work per day? _____________ How many days per week do you work? ___________________

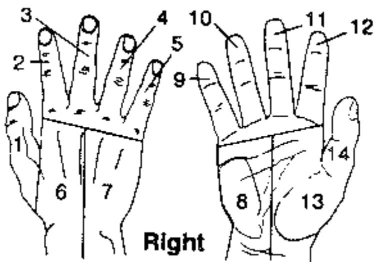
Do you expect to receive further medical treatment? [] Yes [] No Physician Name: __________________________________

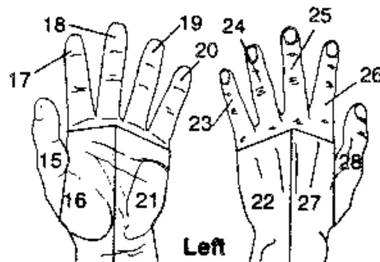
Any Previous accidents? [] Yes [] No If yes, when: ____

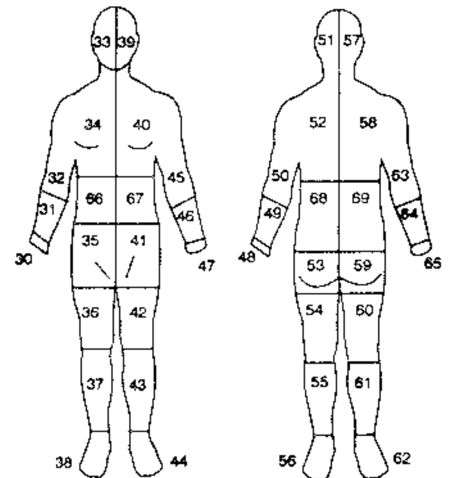
Who was your doctor for the previous accidents? ____

SITE OF INJURY ON BODY:

List the Number(s) of the Location(s) that were injured : _______________________________________







I give my permission for Aim Leasing Company dba AIM NationaLease, or its agent to obtain all necessary medical records. I authorize all physicians treating me, and/or medical facilities, to release requested medical information to Industrial First, Inc. or its agent. A copy of this release is as valid as a copy. I also understand that I must return to my department and give management written instructions from the treating physician, before going home. I further understand that falsification of this form could result in disciplinary action, including dismissal.

Employee Signature: ____ **Date:** ___________________________

SUPERVISOR STATEMENT: I have reviewed the above Employee Accident Report and have attached the Supervisor Injury Investigation Report and, if appropriate, witness statement(s).

Supervisor Signature: **Date:**