TRUMBULL COUNTY
EDUCATIONAL
SERVICE CENTER

For Office Use Only
Claim _____

EMPLOYEE ACCIDENT/BATTERY REPORT

This form must be completed and submitted to TCESC human resources within 24 hours of the accident. The form may also be faxed.

Name: _____ Social Security Number (Required):_____
Position: _____Department: _____ Work Location: _____

Time Accident/Battery Occurred: Date: _____ Exact Time: _____ A.M. P.M.
Location Accident/Battery Occurred: *(Be specific)* _____

Extensively describe the accident/battery:
Include what you were doing at the time of the accident/battery and anything that may have caused the accident/battery. Also, include where you were when the accident/battery occurred: parking lot, classroom, restroom, hallway, etc.

_____

_____

_____

_____

_____

Part of Body Injured: *(Be specific)* _____
List Any Witnesses:_____

Hospital/Treatment Center: _____
Date of Treatment:_____ Approximate Time of Treatment:_____
Attending Physician: _____

List Dates Missed from Work:_____
Total Days Missed: _____

Have you filed a Worker's Compensation claim for this accident/battery? Yes No
Have you filed a previous Worker's Compensation claim? Yes No
When: _____ What For: _____
Do you have a preexisting condition that is related to this claim? Yes No

To file Worker's Compensation, you must:

- Notify your employer (supervisor).
- Call CorVel at 1-800-844-2500 to report your injury.
- If medical treatment is necessary, please visit an MCO network physician. Call 1-800-642-7587 or visit www.ohiobwc.com for list of physicians.
- Show CorVel Ohio Worker's Compensation MCO Identification Card at time of service.

Employee's Signature: _____Date:_____
Supervisor's Signature: _____ Date: _____
Director's Signature: _____ Date:_____