LUXOTTICA | EYEMED

ASSOCIATE REPORT OF OCCUPATIONAL INCIDENT/INJURY/ILLNESS

FAX TO OCCUPATIONAL HEALTH, 513-492-6965

SECTION I ASSOCIATE INFORMATION

1. Associate's Name _____ 2. Lux ID# _____ 3. Date of Birth ___/___/___ 4. Sex____ 5. Age____

6. Phone Number ( ) _____ 7(A). Store Number_____ 7(A). State_____ 8. Manager's Name _____

9. Job Title _____ 10. Date of Hire ___/___/___ 11. Job Status_____ 12. Date Assumed Current Position___/___/___

13. Date of Incident ___/___/___ 14. Time of Incident ___:___ 15. Time Shift Began ___:___

SECTION II INCIDENT/INJURY/ILLNESS INFORMATION

16. WHERE DID INCIDENT/INJURY/ILLNESS OCCUR? ☐ Retail Floor ☐ Office ☐ Lab ☐ Break Room ☐ Mall Area ☐ Parking Lot
☐ Central Lab ☐ Resource Center ☐ Warehouse ☐ Other _____

17. DID AN INJURY/ILLNESS RESULT FROM THIS ACCIDENT? ☐ Yes ☐ No

18. WHAT TYPE OF INJURY/ILLNESS OCCURRED? (NATURE OF INJURY)
☐ Cut (170) ☐ Puncture (175) ☐ Cumulative Trauma (700) ☐ Dermatitis (181) ☐ Burn (120) ☐ Fracture (210) ☐ Illness (099)
☐ Sprain/Strain (310) ☐ Contusion/Bruise (160) ☐ Psych/Stress (450) ☐ Electrical Shock (200) ☐ Respiratory Disorder (440) ☐ Abrasion (300)
☐ Animal Bite/Insect (176) ☐ Concussion (140) ☐ Foreign Body (235) ☐ Inflammation (260) ☐ Other _____ (999)

19. TO WHICH BODY PART(S) DID THE INJURY/ILLNESS OCCUR? (BODY PART)
☐ Head (0100) ☐ Face (0140) ☐ Eye (0130) ☐ Neck/Cervical (0206) ☐ Back (0420) ☐ Shoulder (0450) ☐ Trunk/Chest (0400)
☐ Arm (0310) ☐ Elbow (0313) ☐ Wrist (0320) ☐ Hand (0330) ☐ Finger (0340) ☐ Hip (0440) ☐ Leg (0510) ☐ Knee (0513)
☐ Ankle (0520) ☐ Foot (0530) ☐ Multiple (0700) ☐ Respiratory (0850) ☐ Psych (0841) ☐ Other _____ (0000)

20. ON THE DIAGRAM BELOW, INDICATE BODY PART(S) AFFECTED BY THE INJURY/ILLNESS.

21. HOW DID THE INCIDENT/INJURY/ILLNESS OCCUR? (INJURY CAUSE DESCRIPTION)
☐ Slips/Trips/Falls (0A7) ☐ Material/Product Handling (OHA) ☐ Tool Use (OYB) ☐ Struck By/Against (ORM) ☐ Bodily Motion (OMP)
☐ Exposure To Work Environment (OVZ) ☐ Chemical Exposure (OVJ) ☐ Electricity (OYD) ☐ Medical Emergency (OMX)
☐ Lifting/Pushing/Carrying/Manual Handling (OHB) ☐ Car Accident (OGA) ☐ Machine Injury (ONA) ☐ Inj by Animal/Insect (0WW)
☐ Mental Stress (0W9) ☐ Other _____ (OYT)

22. WHAT OBJECT(S) WAS INVOLVED IN THE INCIDENT/INJURY/ILLNESS? (AGENCY)
☐ Floor/Slippery /Water (1952) ☐ Electricity (1510) ☐ Furniture (List) _____ (1900) ☐ Floor Covering (1950)
☐ Ladders (2800) ☐ Animal/Insect (0200) ☐ Other Person (List) _____ (7700) ☐ Chemical (List) _____ (0900)
☐ Drawers (1940) ☐ Boxes/Containers (0600) ☐ Door/Window (0770) ☐ Docks (0760) ☐ Trays (0610) ☐ Conveyors (1300)
☐ Vehicle/Automobile (5600) ☐ Forklift (5635) ☐ Ice/Snow (6250) ☐ Equipment (3000) ☐ Hand Tools (2200) ☐ Lenses/Frames (0630)
☐ Office Equipment (1901) ☐ Stairs (5840) ☐ Other _____ (6700)

23. WHAT WERE YOU DOING IMMEDIATELY PRIOR TO THE INCIDENT/INJURY/ILLNESS?

24. IS THIS ACTIVITY PART OF YOUR NORMAL JOB DUTIES? ☐ Yes ☐ No

25. WERE ANY OTHER ASSOCIATES INVOLVED IN THE INCIDENT/INJURY/ILLNESS? IF YES, LIST THEIR NAMES.
☐ Yes ☐ No List: _____

26. DESCRIBE THE INCIDENT/INJURY/ILLNESS IN YOUR OWN WORDS, INCLUDING THE CAUSE, YOUR ACTIONS, YOUR INJURY/ILLNESS, ETC. (Be sure to include the specific act, such as lift, push, reach, sit, stand, walk, carry, weight of object, etc).

27. LIST THE FIRST AND LAST NAMES OF EVERYONE (for example, associates, managers, customers) **WHO WITNESSED THE INCIDENT/INJURY/ILLNESS.**

28. DID YOU RECEIVE FIRST AID AT THE SITE OF THE INCIDENT/INJURY/ILLNESS? ☐ Yes ☐ No

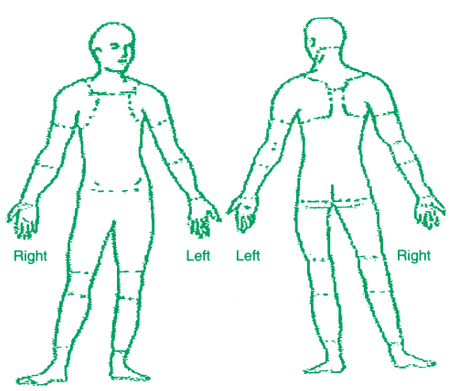
29. DID YOU RECEIVE MEDICAL TREATMENT, OTHER THAN FIRST AID, DUE TO THE INCIDENT/INJURY/ILLNESS? ☐ Yes ☐ No

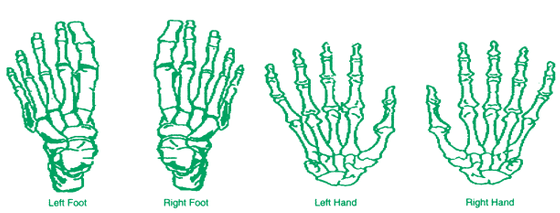
30. IF YOU RECEIVED MEDICAL TREATMENT DUE TO THE INCIDENT/INJURY/ILLNESS, COMPLETE THE FOLLOWING:

(a) DESCRIBE THE TREATMENT YOU RECEIVED:

(b) NAME, ADDRESS AND TELEPHONE NUMBER OF MEDICAL PROVIDER:

(c) WHAT WAS THE DIAGNOSIS?





_____ ___/___/___
ASSOCIATE SIGNATURE DATE

HR-214 (REV 5/10)

PLEASE FAX A COPY OF THIS REPORT TO OCCUPATIONAL HEALTH, 513-492-6965

CP# 3000615