EMPLOYEE'S REPORT OF INJURY

(To be completed and signed by the employee)

SAFETY STATION

_____

Company name _____ Division _____ Clock No. _____

Name (print) _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Phone number (_____) _____ SS# _____

Job title _____ Department _____ Date of hire _____

Date of Injury _____ Time: A.M. P.M. _____ Date injury reported _____

To whom did you report the injury? _____

Where were you when the injury occurred? _____

Witness(es): _____

What activity were you performing when the injury occurred? _____

(example: lifting, pushing, etc.) _____

Describe how the injury happened: _____

_____

_____

_____

_____

_____

_____

_____

Type of injury and what body part was injured? _____

(On the back of this form draw a circle around the exact part of the body which was injured)

Give name and address of treating physician/hospital: _____

_____

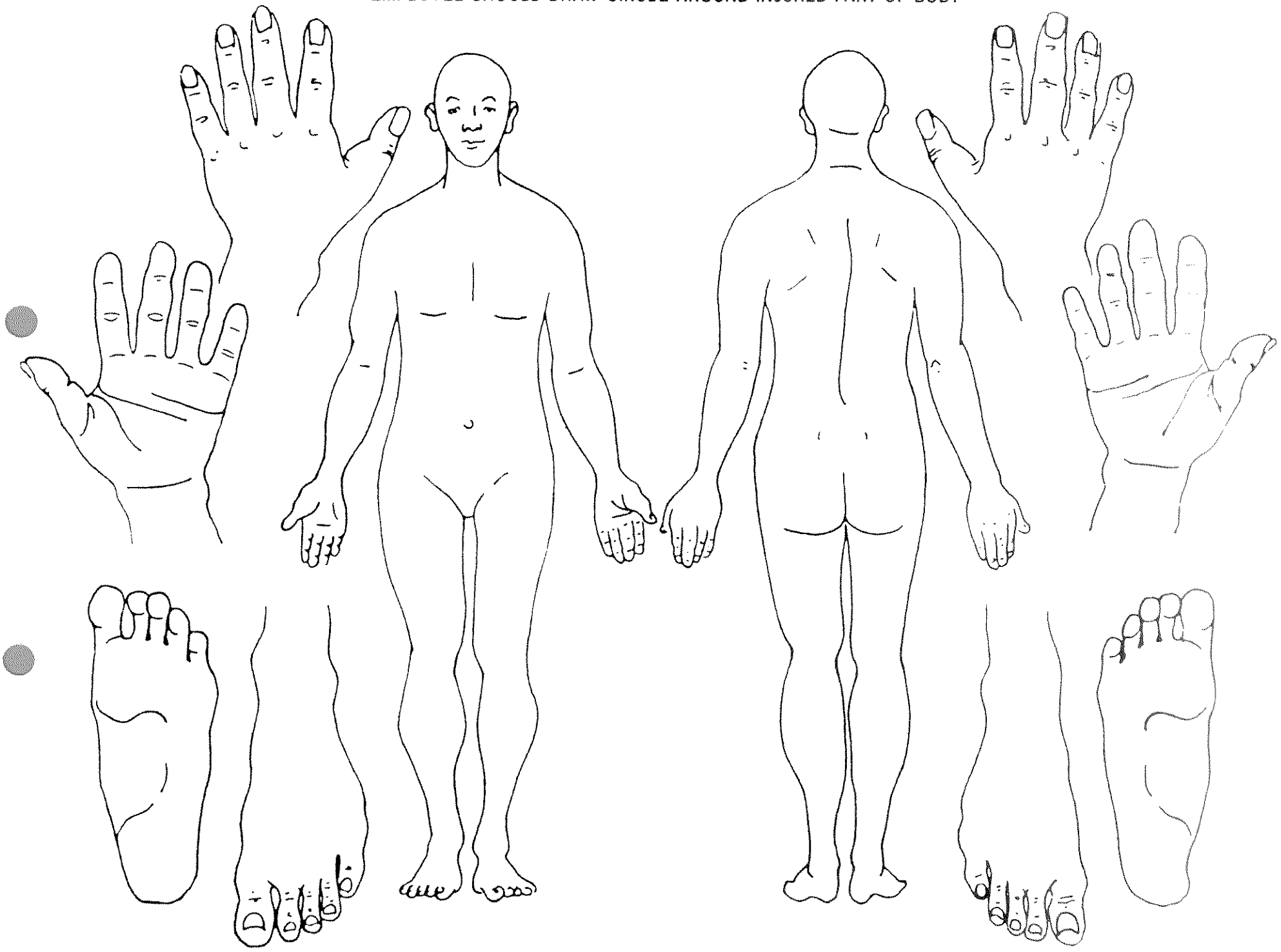
Have you had prior claims or treatment related to the same body part (s)? Yes _____ No _____

This is my description of the accident. As provided by Section 4123.651 (c) of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my Workers' Compensation claim to the Industrial Commission of Ohio, the Ohio Bureau of Workers' Compensation, the employer and its authorized representative, Spooner, Inc., as such medical information, records and reports may possibly pertain to a condition either allowed or alleged in my claim, or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Workers' Compensation claim. A copy shall be as good as the original.

_____ _____

Employee's Signature Date form completed

EMPLOYEE SHOULD DRAW CIRCLE AROUND INJURED PART OF BODY



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