

## EMPLOYEE INCIDENT REPORT (YOU MUST NOTIFY YOUR SUPERVISOR WITHIN 24 HOURS)

### STEP 1

#### EMPLOYEE INFORMATION

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birth Date \_\_\_\_\_  Male  Female  
First Name: \_\_\_\_\_ MI \_\_\_\_\_  
Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Allergies \_\_\_\_\_  
Job Title \_\_\_\_\_ Date Employed \_\_\_\_\_

Building/Wing/Floor \_\_\_\_\_  
Injury Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_ am/pm  
Incident Location \_\_\_\_\_  
Date Reported to Supervisor \_\_\_\_\_  
Supervisor's Name \_\_\_\_\_ Tel. Ext. \_\_\_\_\_  
Department \_\_\_\_\_  
Shift:  Day  Eve  Night  W/E  
Schedule You Work:  8-hr. shift  10-hr. shift  12-hr. shift  >40 hrs./week  
Length of Time in Current Position \_\_\_\_\_  
Other Current Employment \_\_\_\_\_

### STEP 2a

#### EMPLOYEE ACCOUNT OF THE INCIDENT

Describe FULLY the injury and explain in detail what you were doing when the injury occurred, including the use of tools, equipment or materials. What body part was affected? Have you ever required medical treatment for this part of your body before?

### STEP 2b

#### COMPLETE ONLY IF BLOOD AND BODY FLUID EXPOSURE/ANIMAL EXPOSURE

SOURCE NAME OR IDENTIFICATION \_\_\_\_\_ MR# OR ANIMAL CODE# \_\_\_\_\_

#### TYPE OF INCIDENT

Needlestick  Needle used in artery/vein Type of Needle \_\_\_\_\_  Other sharp object \_\_\_\_\_

#### SHARP INFORMATION

Brand Name/Manufacturer of product \_\_\_\_\_

#### TYPE OF EXPOSURE

Body fluid splash  Blood  Urine  Saliva  Wound drainage  Animal scratch  Animal bite  
 Mucous membrane exposure  Eye  Mouth  Nose  Broken skin  Intact skin  Other \_\_\_\_\_

Employee: Hep B vaccine 3 doses?  Yes  No Anti HBS?  Yes  No Last Tetanus \_\_\_\_\_

### STEP 3

I certify that all information given above is true and correct to the best of my knowledge. I understand that any willful or intentional falsification of any information on this report will result in the loss of benefits.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Was there a witness?  Yes  No If yes, name: \_\_\_\_\_ Tel. Ext. \_\_\_\_\_

### STEP 4

#### REPORT TO EMPLOYEE HEALTH SERVICES

After hours, leave name and phone number at appropriate location for follow-up on injuries or exposures and fax incident report.

For EUH, ECC, TEC, and EU, call 404-686-8587. Fax incident report to 404-727-5405.

For CLH, TEC at CLH and TEC satellites, call 404-686-2352. Fax incident report to 404-686-4938.

For WW, call 404-728-6431. Fax incident report to 404-728-6870.

During daytime business hours, employee should complete *Incident Report* and go to Employee Health Office for evaluation.

#### OFFICE USE ONLY

EHI  CLH  ECC  ECCMD  EUH  TECMD  TEC  EU  WWC  WWI

Type of claim (please check one):  Record  Medical  Lost Time Sequence # \_\_\_\_\_ Faxed to TPA on \_\_\_\_\_ by \_\_\_\_\_

EMPLOYEE NAME \_\_\_\_\_

OSHA Recordable?  Y  N  
 Injury  Illness

**HEALTH CARE PROVIDER REPORT**

**TREATMENT**

Exam  Ice/Heat  Splints  Wound Care  Medication \_\_\_\_\_  
 Education  First Aid Only  Other \_\_\_\_\_

**REFERRAL**  Yes  No If yes, where \_\_\_\_\_  
Work Status  Normal Duties  
 Restricted Duties (See RTW Form)  
 Unable to Work until \_\_\_\_\_ First Date of Disability \_\_\_\_\_

**FOR EMPLOYEE HEALTH SERVICES/WORKERS' COMPENSATION USE ONLY**

**NATURE**

- Abrasion
- Allergic rx
- Bite
- Blood exposure
- Body fluid exposure
- Burn
- Carpal tunnel syndrome
- Chemical splash
- Conjunctivitis
- Contusion
- Dermatitis
- Epicondylitis
- Foreign body
- Fracture
- Infection
- Inflammation
- Ingestion
- Inhalation
- Laceration
- Puncture
- Rotator cuff injury
- Soft tissue injury
- Sprain/Strain
- Tendonitis
- Tuberculosis
- None
- Other \_\_\_\_\_

**BODY PART**

- Ankle  R  L
- Arm  R  L
- Back, Upper
- Back, Lumbar
- Chest
- Elbow  R  L
- Eye  R  L
- Finger(s)  R  L
- Foot  R  L
- Hand  R  L
- Head/Face
- Knee  R  L
- Leg  R  L
- Neck
- Shoulder  R  L
- Thumb  R  L
- Wrist  R  L
- Systems:
  - Respiratory
  - Skin
- Other \_\_\_\_\_

**SOURCE**

- Animal
- Blood/Body Fluids
- Bodily Motion
- Chemical
- Co-worker
- Door
- Drugs/Meds
- Equipment
- Fall
- Fluid
- Fumes
- Furniture
- Gloves
- Infection/Disease
- Ladders
- Machines
- Needle
- Patient
- Posture
- Repetitive Motion
- Scalpel
- Steps
- Supplies
- Unknown
- None
- Other \_\_\_\_\_

**TYPE**

- Abduction
- Bodily reactions
- Caught in, under or between
- Contact with substances
- Fall same level
- Fall on stairs
- Faulty equipment
- Flexion/Extension
- Overexertion
- Pronate/Supinate
- Rubbed/Abraded
- Struck by/against
- Sprayed by
- Splashed by
- Other \_\_\_\_\_

HEALTH CARE PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_