Southern Medical Corporation

EMPLOYEE INCIDENT REPORT

Contract Employee: ❐ Yes ❐ No
If yes, contractor:
____
____

If needle stick or body fluid exposure show
Medical records # _____________________

FACILITY # ___________________________________
FACILITY NAME:________________________________
____

PLEASE PRINT. COMPLETE ALL ITEMS

Employee:	Department:	Occupation:
Home or mailing address	City/State Zip:	Home Phone:
Date of injury Age Sex	Shift:	❐ Day ❐ Evening ❐ Night
Date of birth	Soc. Sec. No.	Date of Hire:
Time of injury am pm		Location of incident
Date Reported:	Time reported	Reported to whom?
Work location:		

Employee statement on how incident occurred:

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____

Employee statement on how recurrence of incident could be prevented:

____

____

Attach statement of all witnesses:

NAME OF WITNESS	DEPARTMENT OR ADDRESS	PHONE
(1)		
(2)		

Describe in detail what employee was doing at time of injury (what, how, why).

____

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Body Part injured – Indicate right or left if applicable	TYPE OF INJURY	INCIDENT CATEGORY
❐ head ❐ face ❐ eye ❐ ear ❐ mouth	❐ Reaction to foreign chemical substance	❐ Back injury from lifting pts / objects
❐ heart ❐ back ❐ trunk ❐ arm ❐ wrist	❐ Contagious disease or exposure ❐	❐ Needle stick ❐ Unsafe/defective equipment
❐ hand ❐ finger ❐ knee ❐ leg ❐ ankle	❐ Contusion ❐ Burn ❐ Fracture	❐ pt. Contact ❐ unsafe act/procedure
		❐ fall on floor surfaces ❐ Fall from
❐ foot ❐ toe ❐ hip ❐ neck ❐ shoulder	❐ Sprain ❐ Puncture ❐ Strain	❐ Injury from falling objects ❐ horseplay
❐ groin ❐ thumb ❐ no injury ❐ Other	❐ Blood/bloody fluid exposure ❐ Amputation	❐ Improper use of equipment / instruments
	❐ Reaction to foreign object ❐ cumulative trauma	❐ injury from combative patients

Description of injury:

(1) Was employee given First Aid? ❐ Yes ❐ No
(2) Sent to (circle): First Responder ER Personal Physician
(3) OSHA Recordable? ❐ Yes ❐ No
(4) Was employee placed on modified duty? ❐Yes ❐ No
(5) Will employee lose time from work? ❐ Yes ❐ No
(6) If lost time, approximate days ________
(7) Employee declined treatment? ❐ Yes ❐ No
(8) Sent home? ❐ Yes ❐ No

Date prepared: ________________________ Report prepared by:________________________

Employee signature:________________________ Signature of Supervisor/Department Head:________________________

ALL COPIES TO PERSONNEL

Submit completed form within 24 hours or coverage could be delayed or lost