Supervisor's Incident Report

(Work-Related Injury or Illness)

This form is to be completed and submitted to Human Resources within 24 hours

Human Resources Assigned:

Employee Name_____ Date of Birth_____ ***WC CASE #*** _____

Home Address _____ City _____ Zip_____

Home Phone_____ Work Phone_____ Department_____

Date of Occurrence_____ Time of Occurrence _____ A.M./P.M. Male / Female

Time employee started working_____ A.M. / P.M. Hire Date_____ Occupation_____

Location where accident/incident occurred (be specific)_____

_____

_____

Injury Type (ex: burn, strain, fracture, etc.)_____

_____

Injured Body Part (ex: back, eye, foot, etc.)_____

_____

Who Witnessed Incident? (Include Name(s) and Phone Number(s))

_____

_____

Was First Aid given? No If so, by Whom, When, Explain what was done:

_____

_____

Has treatment been sought? Yes Was employee treated in an Emergency Room? No

Was employee hospitalized overnight as an in-patient? No

Name of Facility and/or Physician _____

Note: For the first 28 days of treatment for an on-the-job injury, in order for claims to be paid you MUST use Munson's Occupational Health clinic at 550 Munson Avenue. You may not use the Emergency Room, unless it is a life-threatening injury. **Services by a physician of your choosing within the first 28 days of treatment will be at your own expense**.

IF **Munson Occupational Health & Medicine** was not used, please explain why _____

_____

IMMEDIATE SUPERVISOR'S SIGNATURE _____ Date _____

(Lost time incidents require the department head to attend the next Physical Resources meeting. Human Resources will notify.)

SUPERVISOR'S INCIDENT REPORT (Page Two)

Employee Name_____ Date of Occurrence_____ **WC CASE #**_____

What was the employee doing just before the incident occurred?_____

_____

Describe injury. (be specific as to part of body & type of injury/exposure)_____

_____

_____

What caused the accident/incident? (be specific as to activity, what object caused the injury and how it caused the injury/exposure)

Machine or equipment involved. (include personal protective equipment being used at the time)

_____

What unsafe acts or conditions contributed to the injury/incident?

_____

_____

Recommended corrective action to prevent recurrence?

_____

_____

What corrective action, if any, has been taken?

_____

_____

If the employee died, list date of death: ____/____/____

Additional Comments/Suggestions?

IF THIS INCIDENT INVOLVED POSSIBLE EXPOSURE TO BLOODBORNE PATHOGENS, PLEASE COMPLETE THIS SECTION:

1. WHAT POTENTIALLY INFECTIOUS MATERIALS WERE INVOLVED?

_____	BLOOD	_____	SEMEN	_____	PERITONEAL FLUID
_____	AMNIOTIC FLUID	_____	CEREBROSPINAL FLUID	_____	SALIVA
_____	VAGINAL SECRETIONS	_____	SYNOVIAL FLUID	_____	OTHER
_____	PLEURAL FLUID	_____	PERICARDIAL FLUID		

2. SOURCE OF THE MATERIAL: _____

3. IMMEDIATE ACTION TAKEN (employee decontamination, clean up, etc.)_____

_____

PLEASE REVIEW THE BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN FOR POST-EXPOSURE EVALUATION/FOLLOW UP (PER085)