McLaren HEALTH CARE

OSHA#: ________________

EMPLOYEE OCCUPATIONAL INCIDENT REPORT

☐ BAY	☐ LANSING	☐ MHC	☐ FLINT	☐ OAKLAND	☐ LONC	☐ KARMANOS		☐ MMG: ________________
☐ BSC	☐ LAPEER	☐ MHP	☐ MNM	☐ CENTRAL	☐ MACOMB	☐ VC	☐ BPT	☐ MHG: ________________

EMPLOYEE SECTION

EMPLOYEE NUMBER	DEPT/OPERATION	INJURY DATE	INJURY TIME	DATE REPORTED TO SUPERVISOR/NAME
NAME		JOB TITLE		SHIFT START STOP
STREET ADDRESS		CITY/STATE/ZIP	☐ FULL TIME ☐ PART TIME ☐ OTHER________________	HIRE DATE
HOME PHONE ( )	WORK PHONE ( )	BIRTH DATE	SEX ☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER

PART OF BODY INJURED *(INCLUDE ALL BODY PARTS INJURED)*

☐ ABDOMEN
☐ ANKLE: ☐L ☐R
☐ ARM: ☐L ☐R
☐ BACK
☐ BUTTOCKS
☐ CHEST
☐ EAR: ☐L ☐R
☐ ELBOW: ☐L ☐R
☐ ENTIRE BODY

☐ EYE: ☐L ☐R
☐ FOOT/TOES:
☐L ☐R
SPECIFY ______________________
☐ GROIN/GENITALIA
☐ HAND/FINGER:
☐L ☐R
SPECIFY ______________________
☐ HEAD/FACE

☐ HEART/CARDIOVASCULAR
☐ HIP/PELVIS
☐ LEG: ☐L ☐R
☐ KNEE: ☐L ☐R
☐ LUNGS/PULMONARY
☐ MENTAL/EMOTIONAL
☐ MOUTH/DENTAL
☐ NECK
☐ NERVOUS SYSTEM

☐ NOSE
☐ SHOULDER: ☐ L ☐ R
☐ UNKNOWN
☐ WRIST: ☐ L ☐ R
☐ OTHER (SPECIFY):
____

DESCRIBE INCIDENT SPECIFICALLY

WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?

WHAT HAPPENED?

WHAT WAS THE INJURY OR ILLNESS?

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORDS TO AUTHORIZED CORPORATE PHYSICIAN, CORPORATE HEALTH OFFICE, INSURANCE CARRIER OR AGENTS FOR CASE MANAGEMENT, WORKERS' COMPENSATION, OR INSURANCE PURPOSES. ☐ TREATMENT REFUSED

SIGNATURE OF EMPLOYEE X DATE:

Incident report completed by:________________________________ **Date:**________________

Title: ________________________________ **Phone: (** **)** ________________

EMPLOYEE NAME:

SUPERVISOR SECTION (***MUST BE COMPLETED BY A SUPERVISOR***)

INJURY TYPE	ACCIDENT/INCIDENT TYPE	CAUSE
☐ ABDOMEN STRAIN ☐ ALLERGIC REACTION ☐ RESPIRATORY ☐ RASH/SKIN ☐ BLOOD/BODY FLUIDS EXPOSURE ☐ NEEDLESTICK/SHARP ☐ CLEAN ☐ CONTAMINATED ☐ SPLASH ☐ HUMAN BITE ☐ BRUISE/CONTUSION ☐ BURN ☐ CRUSH/PINCH ☐ ELECTRIC SHOCK ☐ FOREIGN BODY ☐ EXPOSURE: ☐ CHEMICAL ☐ COMMUNICABLE DISEASE ☐ NO APPARENT INJURY ☐ PUNCTURE ☐ STRAIN/SPRAIN ☐ OTHER____________________	☐ OBJECT LEFT-BEND-TWIST ☐ PATIENT/RESIDENT MOVE FROM/ TO BED-CHAIR-WHEELCHAIR-FLOOR ☐ PATIENT/RESIDENT: TRANSFER TO STRETCHER OR PULL UP IN BED ☐ INHALATION ☐ NEEDLESTICK/SHARP ☐ PULL - PUSH ☐ REPETITIVE MOVEMENT ☐ SKIN ABSORPTION ☐ SPLASH ☐ VEHICLE ACCIDENT ☐ STATIC POSTURE/BODY POSITION ☐ LABORATORY PROCEDURE ☐ HANDLING TRASH ☐ HANDLING LINEN ☐ CLEANING ☐ STRUCK BY - AGAINST ☐ CAUGHT UNDER-BETWEEN-ON-IN ☐ PATIENT AGGRESSION ☐ OTHER____	**WHAT MAY HAVE CONTRIBUTED TO THE INCIDENT? (CHOOSE THE BEST ONE, OTHERS MAY BE DISCUSSED IN DESCRIPTION)** ☐ EQUIPMENT NOT AVAILABLE OR NOT USED ☐ TECHNIQUE (LIFTING, RECAPPING, ETC) ☐ PATIENT COOPERATIVENESS ☐ NO ASSISTANCE AVAILABLE ☐ AWKWARD POSITION ☐ PATIENT SIZE ☐ INSIDE ENVIRONMENT CONDITIONS ☐ OUTSIDE ENVIRONMENTAL CONDITIONS ☐ EQUIPMENT FAILURE/POOR DESIGN ☐ OTHER (DESCRIBE)__________________________ ☐ TRAINING ☐ REACTION ☐ WORKING TOO QUICKLY ☐ IMPROPER DISPOSAL

FOR BACK INJURIES, PLEASE COMPLETE THE FOLLOWING SECTION

WAS LIFTING EQUIPMENT USED: ☐ YES ☐ NO IF YES, INDICATE: ☐ TRANSFER/GAIT BELT ☐ PATIENT LIFT ☐ TRANSFER BOARD/SHEET

WAS PATIENT ASSESSED FOR LIFTING NEEDS: ☐ YES ☐ NO ASSISTANCE REQUIRED BY ASSESSMENT? ☐ YES ☐ NO

WHAT DO YOU SUGGEST TO PREVENT A SIMILAR INCIDENT:

WHAT ACTIONS HAVE BEEN TAKEN?

REFERRED FOR TREATMENT? ☐ YES ☐ NO WHERE?____________________________ REFUSED TREATMENT? ☐ YES ☐ NO EMPLOYEE HEALTH INFORMED? ☐ YES ☐ NO

SUPERVISOR SIGNATURE ____ DATE SIGNED ____________________________________

EMPLOYEE HEALTH SECTION

TREATMENT (IF EMPLOYEE TREATED IN EMERGENCY DEPARTMENT, MUST FOLLOW-UP WITH EMPLOYEE HEALTH.)

☐ NO TREATMENT ☐ REFUSED TREATMENT

☐ FIRST AID (ONE-TIME TREATMENT AND SUBSEQUENT OBSERVATION OF MINOR SCRATCHES, CUTS, BURNS, SPLINTERS, AND SO FORTH WHICH DO NOT ORDINARILY REQUIRE MEDICAL CARE)

☐ MEDICAL TREATMENT: NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL:______________________________

☐ EMERGENCY DEPT ☐ REFERRED TO OCC MED ☐ OTHER FACILITY ______________________________

ADDRESS:______________________________

BRIEFLY DESCRIBE EVALUATION/TREATMENT/INSTRUCTIONS ______________________________

____

____

SECURITY NOTIFIED OF POSSIBLE AGGRESSIVE BEHAVIOR? ☐ YES ☐ NO ☐ N/A DATE: ______________________________

IF THE EMPLOYEE DIED, WHEN DID DEATH OCCUR: DATE OF DEATH:______________________ IN PATIENT HOSPITALIZATION? ☐ YES ☐ NO

SIGNATURE:____ DATE SIGNED: ____