Your Hospital's Logo Here

Occupational Health Services ■ Street Address ■ City, State Zip
Tel: 202 / 555 - 1212 ■ Fax: 202 / 555 - 1212

REPORT OF OCCUPATIONAL INJURY / ILLNESS

Associate must complete this form, obtain **Director or Nurse Manager's signature**, and bring completed form to OCCUPATIONAL HEALTH within **48 hours** of injury. If OCCUPATIONAL HEALTH is closed, report to the Nursing Administrative Supervisor. If injury occured outside clinical area, report to Security.

DATE OF INJURY:	DAY OF INJURY:	TIME OF INJURY: ☐ am ☐ pm

ASSOCIATE NAME: *(Last)* *(First)* *(M.I.)*	SOCIAL SECURITY #:

ADDRESS: *(Number and Street)* *(City)* *(State)* *(Zip)*

HOME PHONE #:	WORK EXTENSION #:	AGE:	DATE OF BIRTH:

DEPARTMENT:	UNIT:	SUPERVISOR:

TITLE: ☐ Associate ☐ Student ☐ Volunteer ☐ Other: _____	WAS THIS YOUR USUAL JOB ? ☐ Yes ☐ No	NORMAL SHIFT START TIME: _____ ☐ am ☐ pm

DESCRIBE FULLY THE EVENTS WHICH RESULTED IN INJURY OR ILLNESS (include equipment or machinery related to event

1. WHAT WERE YOU DOING WHEN INJURED?

2. TYPE OF INJURY AND SPECIFIC BODY PARTS AFFECTED:

3. DESCRIBE PRIOR RELATED INJURY OR ILLNESS:

4. LOCATION AT TIME OF EVENT (Be Specific): | ROOM # (if applicable):

5. NAME(S) OF WITNESS(ES):

6. THIS INJURY WAS THE RESULT OF: ☐ Bloodborne Pathogen Exposure ☐ Patient Handling ☐ Slip, Trip or Fall ☐ Other: _____

7. HAVE YOU LOST WORK DAYS FOR THIS INURY OR ILLNESS? ☐ Yes → IF "Yes", HOW MANY? _____ ☐ No

8. HAVE YOU RECEIVED TREATMENT FOR THIS INURY OR ILLNESS? ☐ Yes → IF "Yes", WHERE? ☐ No

☐ Emergency Room: *Facility Name:* | DATE:

☐ Private Physician: *Name:* | DATE:

ASSOCIATE'S SIGNATURE:	DATE:
ON-DUTY SUPERVISOR'S SIGNATURE:	DATE:
DIRECTOR / NURSE MANAGER'S SIGNATURE:	DATE:

WHITE = Occupational Health Services **YELLOW** = Department Director of involved Associate

PROCEDURE FOR COMPLETING
REPORT OF ASSOCIATE OCCUPATIONAL INJURY / ILLNESS

Every occupational injury or illness should be investigated and its causes corrected, so that similar incidents do not occur. No incident should be considered "unimportant". It is only through investigation that many of the real causes of accidents and injuries can be determined and steps taken to correct problem areas.

1. This report must be completed with Supervisor or Department Director responsible for the area in which the event occurred. The Supervisor should investigate the accident scene prior to completing this report. Safety practice violations, as well as faulty equipment, should also be noted.

   In the event the appropriate Supervisor or Department Director is not available (for example, evenings or nights), the Safety & Security Supervisor should be called to complete this report.

2. This report must be completely filled out, with all questions completed in legible writing.

3. The original copy (WHITE paper) of the completed report must be forwarded to Occupational Health Service within 48 hours of the event.

   The NCR copy (YELLOW paper) should be retained by involved associate's Department Director.

   The Human Resources Department is required to report accidents to the Department of Labor within 10 days of event occurrence; failure to do so may result in the Hospital being fined $500.00 (for each non reported accident: Section 30 of the Longshoremen's & Harbor Worker's Compensation Act).

4. Accidents occuring outside of a specific departmental area (such as corridors, lobby areas, parking lots, stairwells or unsupervised areas) must be reported to the Safety and Security Supervisor, who will initiate this report.

5. Departmental Directors responsible for the area where the incident occurred are required to review and sign all Reports of Injury / Illness. If the event occurred outside of an associate's department, that associate's Department Director must also sign the report.

6. In describing the accident, the Supervisor should indicate whether they personally witnessed the event or are reporting which someone else has told them. Phrases such as "I saw" or statement of act indicate personal observation. Phrases such as "it was reported to me that ...." indicate the Supervisor did not personally witness the event.

7. This report must be brought to Occupational Health Services by the injured Associate.

DIRECTOR / NURSE MANAGER'S INVESTIGATION REPORT

Priviledged and Confidential Information

(Complete and forward to RISK MANAGEMENT no later than two weeks after the event)

1. DATE INJURY REPORT RECEIVED BY SUPERVISOR / DIRECTOR:

2. WAS THIS A PREVENTABLE INJURY / ILLNESS? ☐ Yes → IF "Yes", EXPLAIN HOW EVENT COULD HAVE BEEN PREVENTED: ☐ No

3. CAUSE OF INJURY or ILLNESS *(Elaborate):*

4. CONTRIBUTING FACTORS TO THIS EVENT:
☐ Under Staffing ☐ Equipment Related ☐ Personal Protective Equipment Not Used
☐ Wet Floor ☐ Weather Related ☐ Safety Practices Not Followed *(explain)*
☐ Other: ----------

5. **ACTION PLAN:**
(MUST be completed within two weeks)

	DATE ACTION TAKEN	DATE ACTION COMPLETED
☐ Discussed with Associate ***(mandatory)***		
☐ Training Need Identified		
☐ Job Specific Safety Education / Training *(may include video)*		
☐ Injury Prevention Course		
☐ Provide Initial / Refresher Body Mechanics Training		
☐ Review Job / Task / Safety Issues with Associate		
☐ In-Service		
☐ Reinforce Policy / Procedure		
☐ Infection Control		
☐ Safety Manual		
☐ Human Resources		
☐ Departmental Policy / Procedure		
☐ Other: _____		
☐ Disciplinary Action Needed ***(reasons below)***		
☐ Untimely Reporting (SM 1-1-13 a,d)		
☐ Unsafe Work Practices (SM 1-1-13)		
☐ Preventable Injury (SM 1-1-13, SM 1-1-15)		
☐ Injured Associate at Fault (SM 1-1-13)		

6. **CORRECTIVE RECOMMENDATIONS:**

	DATE ACTION TAKEN	DATE ACTION COMPLETED
☐ Environmental Repairs		
☐ Purchased New Equipment		
☐ Created New Policy / Procedure		
☐ Hazard Removal *(describe):* _____		
☐ Consult with:		
☐ Occupational Health ☐ Housekeeping ☐ Security		
☐ Maintenance & Engineering ☐ Infection Control		
☐ Other _____		

7. DIRECTOR / NURSE MANAGER'S SIGNATURE: DATE:

8. RISK MANAGEMENT FOLLOW-UP AND RECOMMENDATIONS: