PACE North

Employee Incident Report

EMPLOYEE to complete page (1)

Employee Name: _____ Job Title: _____

INCIDENT DATE: _____ **INCIDENT TIME**: _____ ☐ **AM** ☐ **PM**

Date incident report was completed: _____ Incident was reported to:

Description of incident:

_____

_____

_____

_____

Witnessed: ☐ **YES** ☐ **NO** If yes, please list witness name(s) below:

_____ _____ _____ _____

Name Job Title Name Job Title

Location of Incident:

PACE Center: ☐ Large Day Room ☐ Small Day Room ☐ Clinic ☐ Bathroom ☐ Other:_____

☐ Grounds ☐ Parking Lot (front / back) ☐ Off premise: _____

Body part injured: (check all that apply)

☐ Not injured
☐ Back ☐upper ☐middle ☐lower
☐ Head/Face
☐ Ear ☐Left ☐Right
☐ Eye ☐Left ☐Right
☐ Mouth/ Dental
☐ Nose
☐ Shoulder (Left / Right)
☐ Arm ☐Left ☐Right
☐ Elbow ☐Left ☐Right
☐ Neck
☐ Wrist ☐Left ☐Right
☐ Hand/Fingers ☐Left ☐Right
☐ Foot/Toes ☐Left ☐Right
☐ Chest
☐ Abdomen
☐ Leg ☐Left ☐Right
☐ Groin/Genitalia
☐ Buttocks
☐ Knee ☐Left ☐Right
☐ Ankle ☐Left ☐Right
☐ Hip/Pelvis ☐Left ☐Right
☐ Other: _____

Type of injury: (check all that apply)

☐ No apparent injury
☐ Strain / Sprain
☐ Bruise / contusion
☐ Spasm
☐ Burn
☐ Cut / laceration / abrasion
☐ Fracture / break / dislocation
☐ Foreign body
☐ Allergic reaction
☐ Needlestick
☐ Other injury:

_____

☐ Exposure: ☐ blood ☐ body fluid ☐ chemical

Cause of injury:

☐ Lift / transfer of participant: ☐1-person ☐ 2-person ☐ Mechanical
☐ Awkward position
☐ Repositioning participant
☐ Pushing ☐ Pulling ☐ Reaching
☐ Preventing participant fall
☐ Lift / transfer of object
☐ Slip ☐ Trip ☐ Fall
☐ Repetitive motion
☐ Participant inflicted: ☐ hit ☐ kick ☐ grab ☐ push ☐ bite ☐ spit ☐ other
☐ Struck by object
☐ Equipment related (describe): _____
☐ Other (describe): _____

I hereby authorize release of medical information from medical records to authorized corporate medical staff, insurance carrier or agent for case management, workers' compensation or insurance purposes. These records may contain information regarding alcohol and/or abuse, psychological/psychiatric records, HIV testing, AIDS, or ARC records. I understand that drug and alcohol testing may be required if there is reasonable suspicion in connection with a work related injury that requires medical treatment.

Employee Signature: _____ **Date**: _____

I am Requesting treatment: ☐ **YES** ☐ **NO** **(Employee initials)** _____ **Date:** _____

SUPERVISOR to complete page (2)

Did you investigate the scene? ☐ **YES** ☐ **NO**

Date of incident: _____
Time of incident: _____ ☐ AM ☐ PM
Date incident was reported to you: _____

Employee's task/activity at time of incident:

_____
_____
_____
_____

Was a participant involved in the incident? ☐ Yes ☐ No If yes, please complete a participant incident form

Contributing factor(s) – check all that apply

	Description:
Improper lifting technique	☐ _____
Wrong equipment for the task	☐ _____
Equipment not used as directed	☐ _____
Equipment malfunction	☐ _____
Size of object or participant	☐ _____
Awkward position	☐ _____
Uncooperative / agitated participant	☐ _____
Repetitive motion	☐ _____
Environmental deficiencies (wet floor, icy walkway, etc)	☐ _____
Failure to follow policy/procedure	☐ _____
Lack of training / unclear directions	☐ _____
Carelessness / not paying attention	☐ _____
Safety measures/protocols not followed	☐ _____
Other	☐ _____

Corrective action(s)

_____
_____
_____
_____
_____

Medical Treatment:

☐ None required
☐ First aid (describe): _____
☐ Other (describe):_____

☐ Occupational Health & Medicine	Date sent: _____	Time sent: _____	☐ AM	☐ PM
☐ Urgent Care	Date sent: _____	Time sent: _____	☐ AM	☐ PM
☐ Emergency Room	Date sent: _____	Time sent: _____	☐ AM	☐ PM

_____ _____
Name of Supervisor Job Title

_____ _____
Signature of Supervisor Date

RETURN TO HUMAN RESOURCES

REVIEW

_____ _____
Signature of Executive Director Date

CONTROL # _____

Submitted to W/C Carrier ☐ YES ☐ NO
Date sent: _____