EMPLOYEE ACCIDENT / EXPOSURE INCIDENT REPORT

Employer: _____ Case No.: _____

Please complete this form accurately and completely. If you need more space, attach an additional sheet, clearly noting the item(s) you are continuing. Completing this form will not necessarily initiate a claim for workers' compensation insurance.

Injured employee name: F: _____ MI: L: _____ Job / Trade: _____

Home address (street & apt): _____ Work site / building: _____

Home address (city, state, zip): _____ Social security no.: _____

Home telephone no.: _____ Work tel. no.: _____ Date of birth: _____ Sex: M F

Date incident occurred: _____ Time occurred: _____ Date/time began work: Date: Time:

Date first reported: _____ Time reported: _____ To whom reported? _____

Date last worked: _____ Date returned to work: _____

Location and address of incident: _____

1. Describe in full how the incident happened (including what employee was doing before and at the time of the incident, and any tools, equipment or materials being used): _____

2. Describe the injury or illness and the parts of the body affected: _____

3. Select either injury or an illness (choose only one): ☐ Injury ☐ Skin Disorder ☐ Respiratory Condition ☐ Poisoning ☐ Hearing Loss ☐ Other Illness

4. Did an object or substance cause injury? Yes No If yes, describe object/substance: _____

   If object, did it penetrate the body? Yes No _____

   If yes, was it removed from the body? Yes No If yes, who has the object? _____

5. Was personal protective equipment being used at the time of incident? Yes No If yes, describe equipment: _____

   Did the equipment fail? Yes No If yes, describe the failure: _____

6. Classify incident (choose only one):
   ☐ Slip, trip or fall ☐ Assault, fight or violent act ☐ Harmful substance
   ☐ Vehicle accident ☐ Collision with object ☐ Human, animal, or insect bite
   ☐ Muscle strain or back injury ☐ Collision with human ☐ Other

IN ADDITION, FILL OUT THIS SECTION IF THE INCIDENT INVOLVED AN EXPOSURE TO SOMEBODY ELSE'S BLOOD OR BODY FLUIDS

To what body fluid was employee exposed? _____ Due to a bite? Yes No

What part(s) of the body became exposed? _____ For how long? _____

Name of source individual(s): _____

Name of guardian of source individual(s): _____

Was first aid given in the field? Yes No If yes, describe first aid given: _____

By whom: _____ Title: _____

Did employee seek medical attention? Yes No If yes, date of medical attention: _____ Hospitalized overnight as in-patient? Yes No

If yes, doctor & location of treatment: _____ Treated in an emergency room? Yes No

Employee current on Hepatitis B immunization? Yes No Employee current on Tetanus immunization? Yes No

Witnesses to the incident: 1 _____ 3 _____

2 _____ 4 _____

Signature of injured employee: _____ Date signed: _____ Supervisor Name: _____

Completed by (if not employee): _____ Title: _____ Date Completed: _____

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