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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