

**REPORT OF OCCUPATIONAL
INJURY OR ILLNESS**

Any person who makes or causes to be made any knowingly false or fraudulent material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

FORM TO BE COMPLETED IMMEDIATELY AFTER INCIDENT							
E M P L O Y E C A U S E N A T U R E	NAME: Last First M.I.		SOCIAL SECURITY NUMBER:		SEX: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	TODAY'S DATE	
	HOME ADDRESS			CITY	STATE	ZIP	HOME PHONE # () -
	DEPARTMENT - DESIGNATED CAMPUS ASHBY <input type="checkbox"/> HERRICK <input type="checkbox"/> SUMMIT <input type="checkbox"/>		JOB TITLE (no abbreviations)		UNION LOCAL	HIRE DATE:	
	HOURS USUALLY WORKED PER DAY _____ DAYS/WEEK _____ TOTAL WEEKLY HOURS _____			EMPLOYMENT STATUS: Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Volunteer <input type="checkbox"/> Per Diem <input type="checkbox"/>			
	DATE OF INCIDENT:		TIME OF INCIDENT:		TIME BEGAN WORK:	MANAGER/SUPERVISOR: Ext:	
	DEPARTMENT WHERE INCIDENT OCCURRED (Give bldg., floor, room no.)				LAST DAY WORKED:		
	INCIDENT REPORTED TO IMMEDIATE SUPERVISOR Name: _____ Date: _____			OTHER EMPLOYEES INJURED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	DID ANYONE WITNESS THIS INCIDENT? NO <input type="checkbox"/> YES <input type="checkbox"/>				PERSONAL PROTECTIVE EQUIPMENT USED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
	WHAT WERE YOU DOING WHEN THE INCIDENT OCCURRED? (i.e., Lifting/moving patient, cleaning floor, typing)						
	HOW DID THE INCIDENT OCCUR? (i.e., Removing boxes from a materials cart, bent over and felt pain in my back)						
	SPECIFY EXACT TYPE OF INJURY: (i.e., Cut, Strain/Sprain, Exposure, Puncture)			BODY PART: (i.e., Right middle finger, low mid back) LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/>			
	HAVE YOU EVER HAD THIS TYPE OF INJURY BEFORE? NO <input type="checkbox"/> YES <input type="checkbox"/> List Prior Injury Dates: _____						
I decline evaluation at this time _____				I will contact Employee Health Services, <i>immediately</i> , regarding evaluation _____			
NAME OF PRIMARY CARE PHYSICIAN:					PHONE:		
I certify that all of the foregoing information is true, correct and complete and that I have not omitted any pertinent information							
EMPLOYEE SIGNATURE:				DATE:			
COMMENTS:							
S U P V.	<input type="checkbox"/> UNSAFE WORK ENVIRONMENT (Unsafe Condition Form completed and forwarded to Safety on _____)			<input type="checkbox"/> UNSAFE WORK PRACTICE			
	IMMEDIATE ACTION TAKEN: _____						
IMMEDIATE SUPERVISOR: _____			(Signature of person in charge required) _____				
EMPLOYEE TREATMENT AND DISPOSITION							
<input type="checkbox"/> SENT TO EMERGENCY DEPARTMENT		<input type="checkbox"/> SENT TO EMPLOYEE HEALTH		<input type="checkbox"/> SEEN BY PRIVATE PHYSICIAN (Name of MD) _____			
<input type="checkbox"/> NO INJURY - TREATMENT NOT NECESSARY		<input type="checkbox"/> OTHER: _____					



1. READ INSTRUCTIONS ON THE BACK
2. COMPLETE THE EMPLOYEE PORTION OF THE FORM
3. TAKE TO SUPERVISOR IN CHARGE TO COMPLETE INJURY INVESTIGATION AND SIGN FORM
4. TEAR OFF WHITE COPY AND BRING TO EMPLOYEE HEALTH, IMMEDIATELY, FOR EVALUATION.

(IF EMPLOYEE HEALTH IS CLOSED, REPORT TO EMERGENCY DEPARTMENT AND THEN FOLLOW UP WITH EMPLOYEE HEALTH THE FOLLOWING BUSINESS DAY)

**Alta Bates Summit Medical Center
Employee Health/Occupational Medicine Department
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