EMPLOYEE INCIDENT REPORT

Facility, A, B, C, (Circle One) Claim No. _____ Year 20_____

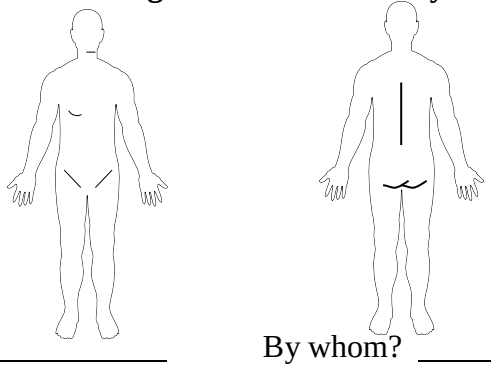
Note: A response to all questions is required unless otherwise indicated. Incomplete forms could result in delay in processing your incident and potentially cause work comp to deny your claim.

Section 1 (to be completed by **SUPERVISOR**) Supv Name and Signature _____

Date of Incident _____ _____ Near Miss ____ Medical Follow-up
Date Supervisor Notified _____ _____ First Aid ____ Property Damage
Date Report completed _____

Section 2 (to be completed by **EMPLOYEE** Start time of employee shift _____

Employee Name (last, first, MI): _____
Employee Home Address: _____
City, State & Zip Code _____
Social Security Number: _____ Date of Birth: _____
Phone Number: _____ How long employed? _____
Department: _____ Job Title: _____
Marital Status _____ Sex _____
Full/Part Time (Circle one) Do you have other regular employment? ☐ Yes ☐ No Where? _____
Supervisor: _____ Who did you notify of this incident? _____
Date of Incident: _____ Time of Day: _____am/pm Day Occurred: S M T W TH F S
Location of Incident (identify Precisely) Room # _____Floor _____ Other info _____
Describe exactly what happened & how the incident occurred. Include details pertaining to equipment, environment, work location, work tasks, etc.: _____
_____ **Indicate on the Diagram the location of your injury(ies):**
_____
_____
_____
_____



Was first aid administered? Yes No When? _____ By whom? _____
Did you go to the Hospital? Yes No When? _____ Where? _____
Did you go to the Clinic? Yes No When? _____ Where? _____
Did you see a physician, chiropractor, nurse practitioner or seek other medical attention? ☐ Yes ☐ No
When? _____ Who? _____ Where? _____
Do you intend to seek additional medical care for this injury? ☐ Yes ☐ No
Who witnessed the incident? _____
How much time did you miss because of this incident? _____ When? _____
What could you have done differently to avoid this incident? _____
_____
What actions do you intend to take to avoid this in the future? _____
_____

Employee's Signature: _____ Date: _____

Section 3 to be completed by **SUPERVISOR**

		YES NO CHECK YES OR NO
1.	Was injured person properly instructed in safe & efficient method?	YES □ NO □
2.	Did injured person violate any instruction/safety procedure?	YES □ NO □
3.	Was necessary protective equipment worn? (if applicable)	YES □ NO □
4.	Did poor housekeeping contribute to accident?	YES □ NO □
5.	Did horseplay cause the accident?	YES □ NO □
6.	Was it caused by something, which needed repairs?	YES □ NO □
7.	Should a guard be provided? (if applicable)	YES □ NO □
8.	Did any bodily defect contribute to accident? (if yes, please specify)	YES □ NO □
9.	Was it caused by any unsafe act?	YES □ NO □
10.	Did injured report the injury to you, the supervisor, immediately?	YES □ NO □
11.	Were appropriate transfer techniques/lifting assist used? (if applicable)	YES □ NO □

(if no, please comment: _____

_____

Above reviewed with employee; employee comments:_____

_____

_____

_____

Employee Signature _____Date _____

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION3, MNWC STATE STATUTE 60A.955

DEPARTMENT REVIEW

As Supervisor, do you feel there are any contributing factors to this injury outside of this incident?

_____ Yes _____ No

Reasons why_____

_____

_____ _____

Supervisor Signature Date

Date employee hired: _____

Department Head comments: _____

_____

_____

_____ _____

Department Head/Nurse Manager Signature **Date**