



Supervisor's Incident Report

(Work-Related Injury or Illness)

This form is to be completed and submitted to Human Resources within 24 hours

		<i>Human Resources Assigned:</i>
Employee Name _____	Date of Birth _____	WC CASE # _____
Home Address _____	City _____	Zip _____
Home Phone _____	Work Phone _____	Department _____
Date of Occurrence _____	Time of Occurrence _____	A.M./P.M. Male / Female
Time employee started working _____	A.M. / P.M.	Hire Date _____ Occupation _____
Location where accident/incident occurred (be specific) _____		
Injury Type (ex: burn, strain, fracture, etc.) _____		
Injured Body Part (ex: back, eye, foot, etc.) _____		
Who Witnessed Incident? (Include Name(s) and Phone Number(s)) _____		
Was First Aid given? YES / NO If so, by Whom, When, Explain what was done: _____		
Has treatment been sought? YES/NO Was employee treated in an Emergency Room? YES / NO		
Was employee hospitalized overnight as an in-patient? YES / NO		
Name of Facility and/or Physician _____		
Note: For the first 28 days of treatment for an on-the-job injury, in order for claims to be paid you MUST use Munson's Occupational Health clinic at 550 Munson Avenue. You may not use the Emergency Room, unless it is a life-threatening injury. Services by a physician of your choosing within the first 28 days of treatment will be at your own expense.		
IF Munson Occupational Health & Medicine was not used, please explain why _____		
IMMEDIATE SUPERVISOR'S SIGNATURE _____		Date _____
(Lost time incidents require the department head to attend the next Physical Resources meeting. Human Resources will notify.)		

Employee Name _____ Date of Occurrence _____ WC CASE # _____

What was the employee doing just before the incident occurred? _____

Describe injury. (be specific as to part of body & type of injury/exposure) _____

What caused the accident/incident? (be specific as to activity, what object caused the injury and how it caused the injury/exposure)

Machine or equipment involved. (include personal protective equipment being used at the time)

What unsafe acts or conditions contributed to the injury/incident?

Recommended corrective action to prevent recurrence?

What corrective action, if any, has been taken?

If the employee died, list date of death: ____ / ____ / ____

Additional Comments/Suggestions?

IF THIS INCIDENT INVOLVED POSSIBLE EXPOSURE TO BLOODBORNE PATHOGENS, PLEASE COMPLETE THIS SECTION:

1. WHAT POTENTIALLY INFECTIOUS MATERIALS WERE INVOLVED?

_____ BLOOD	_____ SEMEN	_____ PERITONEAL FLUID
_____ AMNIOTIC FLUID	_____ CEREBROSPINAL FLUID	_____ SALIVA
_____ VAGINAL SECRETIONS	_____ SYNOVIAL FLUID	_____ OTHER
_____ PLEURAL FLUID	_____ PERICARDIAL FLUID	
2. SOURCE OF THE MATERIAL: _____
3. IMMEDIATE ACTION TAKEN (employee decontamination, clean up, etc.) _____

**PLEASE REVIEW THE BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN
FOR POST-EXPOSURE EVALUATION/FOLLOW UP (PER085)**