Confidential Employee Incident and Illness Report

Form MUST be completed legibly and in its entirety for required and timely processing

This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible. This form contains all information requested on the OSHA Form 301 and can be considered an equivalent form.

Facility Name: Address:

Employee Name: _____	Dept./Unit: _____	Soc. Sec. #_____
Address: _____	Job Title: _____	Birth Date: ___/ ___/__ Sex ☐M ☐F
City & State: _____ Zip: _____	Incident/Illness Date: _____/_____/_____	Time Began Work :_____☐am ☐pm
Home Phone: ( ) _____	Time: _____ ☐am ☐pm	Emp. ID #_____
Work Phone: ( )_____	Reported to Supervisor: ____/_____/_____	Case # from OSHA Log: _____

Describe All Details Surrounding the Incident/Illness - *What you were doing, location, condition of area, any equipment being used, PPE, etc.*

_____

_____

Witness(es) - *Print legibly and include contact phone number(s)*

_____

Reported Part of Body - *include ALL affected body parts*

☐ Abdomen	☐ Chest	☐ Toes - ( ) L ( ) R	☐Knee - ( )L ( )R	☐ Nervous System
☐ Ankle - ( )L ( )R	☐ Ear - ( )L ( )R	☐ Groin/Genitalia	☐ Leg – ( )L ( )R	☐ Nose
☐ Arm - ( )L ( )R	☐ Elbow - ( )L ( )R	☐ Hand – ( )L ( )R	☐ Lungs/Pulmonary	☐ Shoulder - ( )L ( )R
☐ Back - ( )Upper ( )Lower	☐ Entire Body	☐ Fingers - ( )L ( )R	☐ Mental/Emotional	☐ Wrist - ( )L ( )R
☐ Buttocks	☐ Eye - ( )L ( )R	☐ Head/Face	☐ Mouth/Dental	☐ Other
☐ Cardiovascular/Heart	☐ Foot - ( )L ( )R	☐ Hip/Pelvis	☐ Neck	_____

Reported Incident/Illness Type - *Must select one–be specific*

☐ Amputation	☐ Contagious Disease	☐ Exposure-Body Fluid	☐ Loss of Hearing	☐ Sprain/Strain
☐ Asphyxiation	☐ Crushing	☐ Foreign Body	☐ Multiple Physical Injuries	☐ Stress
☐ Burn	☐ Dermatitis/Rash/Skin Reaction	☐ Fracture	☐ Poison or Chemical	☐ Vision Loss
☐ Cumulative Trauma	☐ Dislocation	☐ Infection	☐ Puncture (non-needle)	☐ No Apparent Injury
☐ Concussion	☐ Electric Shock	☐ Inflammation	☐ Puncture-Needlestick/Sharps Only	☐ Other
☐ Contusion/Bruise		☐ Laceration	☐ Respiratory Disorders	_____

Reported Cause – *Must select area –be specific*

☐ Absorption, Ingestion, or Inhalation	☐ Fall or Slip– Liquid	☐ Strain/Injury by Pushing or Pulling
☐ Burn or Scald – Steam or Hot Fluids	☐ Fall or Slip – Same Level	☐ Strain/Injury by – Misc.
☐ Burn or Scald – Acid or Chemicals	☐ Fall or Slip – Stairs or Step	☐ Striking Against/Stepping on - Object
☐ Burn or Scald - Fire	☐ Fall or Slip – Misc.	☐ Struck or Injured by– Person
☐ Caught In, On, or Between– Object	☐ Motor Vehicle Accident	☐ Struck or Injured by– Falling Object
☐ Caught In, On, or Between– Misc.	☐ Repetitive Motion	☐ Struck or Injured by– Moving Parts or Machine
☐ Cut, Puncture, Scrape– Hand Tool	☐ Strain/Injury by Lifting– Patient	☐ Struck or Injured by– Object Being Lifted
☐ Cut, Puncture, Scrape– Object Being Lifted	☐ Strain/Injury by Lifting– Non Patient	☐ Struck or Injured by– Misc.
☐ Cut, Puncture, Scrape– Misc.	☐ Strain/Injury by Pushing or Pulling– Patient	☐ Other _____
☐ Fall or Slip– Ice or Snow		

I hereby attest that the information provided above is true and factual

Employee Signature: _____ **Date:** _____/_____/_____

Refused Treatment:_____ *(Initial)* **Date:** _____/_____/_____

MANAGER COMMENTS – *Please ensure form is completed in its entirety and provide any comments here*

_____

_____

Manager Signature: _____ **Print Name Legibly:**_____ **Date:**_____

Referred for Treatment: ☐ Yes ☐ No ☐ Internally ☐ Externally - include location & address:_____

☐ Treated in ED ☐ Hospitalized ☐ Deceased Date: _____/_____/_____ Time: _____ ☐am ☐pm

Name of Physician or Health Care Professional:_____

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Employee: _____ **SS#**_____**DOI:**_____/ _____/ ____

INJURIES RESULTING FROM ASSISTING PATIENTS

Was lifting/guiding assistance used? ☐ Yes ☐ No

If yes, indicate ☐Transfer/gait belt ☐Mechanical lift ☐Transfer board/sheet ☐ Other_____

Was patient assessed for lifting needs? ☐ Yes ☐ No Was assistance required by the assessment? ☐ Yes ☐ No

NEEDLESTICK INCIDENTS *(This section is for information gathering only – not to be used as a "sharps injury log")*

The needlestick incident occurred when:

- ☐ Disposing of a needle
- ☐ Recapping of a needle
- ☐ Drawing blood
- ☐ Giving an injection
- ☐ Cleaning
- ☐ Handling/emptying trash
- ☐ Handling sharps container
- ☐ Handling laundry
- ☐ Assisting w/patient procedure
- ☐ Involving an IV
- ☐ Involving a surgical procedure
- ☐ Involving a laboratory procedure
- ☐ Involving patient aggression
- ☐ Involving a clinical procedure
- ☐ Other _____

Was protective equipment used? ☐ Yes ☐ No

If yes, what type? ☐ Gloves ☐ Face shield ☐ Gown/apron ☐ Goggles/safety glasses ☐ Other_____

Device type (i.e. syringe, suture needle): _____ Device brand and specific product:_____

Work unit or work area of incident: _____

Description of how incident occurred:_____

_____

TREATMENT

☐ First aid (one-time treatment and later observation of minor scratches, cuts, burns, splinters , etc. - do not ordinarily require medical care)

☐ Medical treatment (management and care for disease or disorder administered by physicians, registered professionals, or lay persons)

Briefly describe diagnosis/actions and treatment_____

_____

Work status

☐ Off work ☐ Return to full duty on: _____/ _____/ _____ ☐ Return to work w/restrictions on: _____/ _____/ _____

Please describe specific restrictions or special/discharge instructions:_____

_____

Employee should return for follow up on _____/ _____/ _____ Location: _____

Signature: _____ Date: _____/ _____/_____

Underlying/Root Causes Identified:	Corrective Action to be Taken (Include target date(s)
1.	1.
2.	2.

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3.	3.

Investigation completed by (print legibly)_____ Date: ____/ ____/____

Date report presented to Safety Committee: _____ /_____/_____

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