PENNYBYRN - EMPLOYEE INCIDENT REPORT

Name Sex

Address

SS# Date of Birth Phone #

☐ FT ☐ PT ☐ PRN

Department

Job Title

Date of Hire

Date of Incident Time of Incident

Time punched in Location working

Today's Date

Type of Injury:
- ☐ Laceration/Abrasion
- ☐ Needle Puncture
- ☐ Burn
- ☐ Bruise
- ☐ Bite/Scratch
- ☐ Strain/Sprain
- ☐ Fracture
- ☐ Other_____

Part of Body:
- ☐ Head
- ☐ Face/Neck
- ☐ Back (Upper/Lower)
- ☐ Chest
- ☐ Hand / Wrist (L/R)
- ☐ Leg / Knee (L/R)
- ☐ Arm / Shoulder (L/R)
- ☐ Foot / Ankle (L/R)
- ☐ Other_____

Activity Involved:
- ☐ Lifting resident
- ☐ Lifting Other _____
- ☐ Handling Resident
- ☐ Handling Equipment
- ☐ Equipment Use
- ☐ Other Patient Care _____
- ☐ Other_____

Did you report the incident? ❑ YES ❑ NO

Time _____ Date _____

Name of person you reported incident to

Was there a witness to incident? ❑ YES ❑ NO

Witness Name

Did an injury occur? ☐ YES ☐ NO If so, describe the incident fully: _____

Treatment:
- ☐ None Necessary
- ☐ First-Aid
- ☐ Refused treatment
- ☐ Other_____

Describe treatment:

Do you required medical attention? ☐ YES ☐ NO

First-Aid given by:

Name:

Title & Dept:

Date:

Disposition:
- ☐ Return to work
- ☐ Sent Home
- ☐ Referred to Doctor/Urgent Care
- ☐ Referred to Emergency Room
- ☐ Other _____

Did employee leave work due to incident? ☐ YES ☐ NO

Time & Date left work

Employee Signature Date

Completed by (if different from Employee) Date

Supervisor Signature Date

Employee recommendation on how to prevent this incident from recurring? _____