

VOLUNTEER

# Central Baptist Hospital Employee Incident Report

**Note:** Any person who knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Name \_\_\_\_\_ SS# \_\_\_\_\_  
Your Department \_\_\_\_\_ Your Daily Work Hours \_\_\_\_\_  
Number of Hours Worked Per Day \_\_\_\_\_ Number of Hours Worked Per Week \_\_\_\_\_  
Date of Incident \_\_\_\_\_ Time of Incident \_\_\_\_\_ Place of Incident \_\_\_\_\_

### NATURE OF INCIDENT (check all that apply)

- |                      |                          |                                  |                          |                                 |                          |
|----------------------|--------------------------|----------------------------------|--------------------------|---------------------------------|--------------------------|
| Allergic Reaction    | <input type="checkbox"/> | Cortusion/abrasion               | <input type="checkbox"/> | Lifting                         | <input type="checkbox"/> |
| Assault              | <input type="checkbox"/> | Equipment misuse/<br>malfunction | <input type="checkbox"/> | Needle stick/<br>puncture wound | <input type="checkbox"/> |
| Back Injury          | <input type="checkbox"/> | Exposure                         | <input type="checkbox"/> | Pushing/pulling                 | <input type="checkbox"/> |
| Body Fluid/Splash    | <input type="checkbox"/> | Type _____                       | <input type="checkbox"/> | Self Inflicted Injury           | <input type="checkbox"/> |
| Burn                 | <input type="checkbox"/> | Eye Injury                       | <input type="checkbox"/> | Struck by/against               | <input type="checkbox"/> |
| Caught in/on/between | <input type="checkbox"/> | Ingestion/Inhalation             | <input type="checkbox"/> | Other _____                     |                          |
| Fall/Slip            | <input type="checkbox"/> |                                  |                          |                                 |                          |

List personal protective equipment worn (if not, reason) \_\_\_\_\_

Describe exactly what happened; why it happened, and the causes.  
If injury, state the part of the body injured \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and title of eyewitnesses \_\_\_\_\_

Were you seen by: Health Nurse  Emergency Physician  Not Seen

### TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER

Physician/Healthcare provider name and title \_\_\_\_\_  
List any medications prescribed \_\_\_\_\_  
Diagnosis and treatment provided \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature/title of person preparing report \_\_\_\_\_ Date of report \_\_\_\_\_  
Other comments \_\_\_\_\_