EMPLOYEE INCIDENT REPORT

Note: Please complete this form and return it to your supervisor immediately. Please complete each question and if you need medical attention, call: _____

Employee Name (last, first, middle): _____

Employee Home Address: _____

City, State & Zip Code _____

Social Security Number: _____ Date of Birth: _____

Phone Number: _____ How long employed? _____

Department: _____ Job Title: _____

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: _____

Describe exactly what happened & how the incident occurred. Include details pertaining to equipment, environment, work location, work tasks, etc.: _____

_____

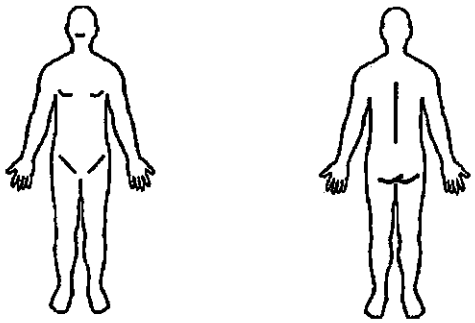
_____

_____

_____

_____

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 actions do you intend to take to avoid this in the future? _____

_____

Do you have other regular employment? ☐ Yes ☐ No Where? _____

Employee's 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.

Supervisor's Report of Accident Analysis

SS# [redacted]

Name of Injured: _____ Work Phone No. _____ Home Phone No. _____

☐ Full Time ☐ Part Time ☐ Temporary ☐ Seasonal ☐ Other

Sex: ☐ M ☐ F Shift: ☐ 1 ☐ 2 ☐ 3 ☐ Other Job Title: _____ Dept: _____

Date of Hire: _____ Time on Present Job: _____

Date of Accident _____ Time: _____ am/pm (If date of accident and date reported differ, please explain why.)

Date Reported: _____ Time: _____ am/pm _____

Date Medical Treatment: _____ Location of Medical Treatment: _____

Phase of employee's workday at time of injury (check one) ☐ Entering or leaving facility ☐ Performing work duties ☐ Working overtime ☐ During break

Place of Accident: _____ (Indicate Department and Workstation) Witnesses: _____ (Name and Phone Number)

Explain the activity being performed at the time of the injury including any contributing causes. (Brief summary of incident): _____

_____

_____

Please check all that apply.

CAUSE

- ☐ Machine
- ☐ Conveyor, Elev., Hoist
- ☐ Vehicle
- ☐ Hand Tool
- ☐ Chemical
- ☐ Work Surface, Table, Bench
- ☐ Floor, Walking Surface
- ☐ Box, Barrel, Container
- ☐ Door, Window, Etc.
- ☐ Ladder
- ☐ Lumber, Woodwork Material
- ☐ Metal
- ☐ Stairway, Steps
- ☐ Glass
- ☐ Knife
- ☐ Lack of Training
- ☐ Unsafe Procedure
- ☐ Housekeeping
- ☐ Lack of Personal Protective Equip.
- ☐ None
- ☐ Other _____
- ☐ Unknown

BODY PART

- ☐ Head ☐ RIGHT SIDE ☐ LEFT SIDE
- ☐ Multiple Head
- ☐ Ear(s)
- ☐ Eye(s)
- ☐ Teeth
- ☐ Face
- ☐ Neck
- ☐ Upper Extremities
- ☐ Multiple Upper Extremities
- ☐ Elbow ☐ Upper Arm
- ☐ Wrist ☐ Lower Arm
- ☐ Hand ☐ Thumb
- ☐ Trunk ☐ Second Finger
- ☐ Multiple Trunk ☐ Third Finger
- ☐ Shoulders ☐ Fourth Finger
- ☐ Upper Back ☐ Fifth Finger
- ☐ Lower Back
- ☐ Chest
- ☐ Sacrum, Coccyx, Pelvis
- ☐ Internal Organs
- ☐ Lower Extremities
- ☐ Multiple Lower Extremities
- ☐ Hip ☐ Thigh
- ☐ Knee ☐ Lower Leg
- ☐ Ankle ☐ Foot
- ☐ Toes
- ☐ Other _____

TYPE

- ☐ Lift
- ☐ Carry
- ☐ Push
- ☐ Pull
- ☐ Fall from Elevation
- ☐ Fall on Same Level
- ☐ Struck Against
- ☐ Struck by
- ☐ Caught in, Under, Between
- ☐ Rubbed or Abraded
- ☐ Bodily Reaction
- ☐ Overexertion
- ☐ Contact Electrical Outlet
- ☐ Contact Temperature Extreme
- ☐ Contact Hazardous Substance
- ☐ Stepped On or In
- ☐ Motor Vehicle Accident
- ☐ Repetitive Motion
- ☐ Awkward Position
- ☐ Normal Procedures
- ☐ Carpal Tunnel
- ☐ Patient/Resident handling
- ☐ Materials Handling
- ☐ Body Fluid Exposure
- ☐ Contaminated Sharps Exposure
- ☐ Other _____
- ☐ Unknown

NATURE

- ☐ Amputation
- ☐ Bruise, Contusion
- ☐ Burn (Chemical)
- ☐ Burn & Scald (Heat)
- ☐ Concussion
- ☐ Crushing Injury
- ☐ Cut, Laceration, Puncture
- ☐ Dermatitis
- ☐ Dislocation
- ☐ Fracture
- ☐ Foreign Body
- ☐ Freezing
- ☐ Hearing Loss
- ☐ Hernia
- ☐ Heat Stress
- ☐ Infection
- ☐ Work Illness
- ☐ Sprain, Strain
- ☐ Other _____

SEVERITY

- ☐ Near Miss
- ☐ First Aid
- ☐ Doctor Visit
- ☐ Lost Time
- ☐ Hours Lost _____

What acts and conditions were involved? What caused them? How will they be corrected? (If injury event is unknown, leave blank and complete questions below.)

Unsafe Act/Condition	Possible/Probable Cause	Correction/Suggested Correction	Date Corrected
1.			
2.			
3.			

If an employee reports a symptom that he/she does not know or is uncertain of the cause, please ask the employee the following questions. Record his/her responses accurately.

1. When did you first notice the symptom? _____
2. What caused you to notice the symptom? _____
3. What new or unusual activity have you performed during the week(s) previous to the first symptom?

_____

4. Have you ever noticed this symptom before in your life? If so, when?

_____

5. Have you been involved in any accident or unusual event in the week(s) previous to this symptom? _____

_____

6. What activities have you been involved in at home in the day(s) prior to this symptom? _____

_____

7. What sport or recreational activities were you involved in before you noticed the symptom? _____

_____

8. What hobby or other jobs were you involved in during the week before you noticed this symptom? _____

_____

Completed By: _____

Date: _____

Dept. Supervisor: _____ **Ext.** _____

Date Received by WC Manager: _____

Other Comments:

OFFICE USE ONLY

- ☐ OSHA Reportable
- ☐ OSHA Non-Reportable
- ☐ Sent to WC Carrier (date): _____

Benefit Coordination

- ☐ FLMA ☐ ADA
- ☐ LTD ☐ STD
- ☐ Sick Benefits
- ☐ Vacation Benefits

COMPENSIBILITY

☐ May not be Work Related (please explain)

COMMENTS

INJURY MANAGEMENT PROGRAM
Injured Workers' Responsibilities

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the State of Minnesota workers' compensation laws. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

Minnesota Rule Number 5221.0430 Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

Notify your employer immediately of any new injuries or conditions that impact your physical condition.

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

I have read my responsibilities and agree to abide by these guidelines.

Signed: _____

Printed Name: _____

Employer Representative: _____

cc: **Employee**
Employer file
Claims Representative