



Phoenix Alternatives, Inc.

EMPLOYEE INCIDENT OR INJURY REPORT

Name of Injured: _____		Incident Date & Time: _____		
_____	_____	_____	_____	_____
Home Address	City	State	Zip	Date of Birth
_____	_____	_____	_____	_____
Phone	Cell	Incident Location	Start Time On Day Of Injury	
_____	_____	_____	_____	

Procedure:

1. Employees need to report any injury or suspected injury to the Coordinator and Program Director or designee as soon as possible.		
2. The injured employee will complete the employee section of this report.		
3. The Director or designee calls HR (President if HR unavailable) and reports the incident <u>immediately</u> upon receipt of the verbal report.		
4. The Director or designee reviews the first page for accuracy and completes the second page with the employee.		
5. The Director or designee immediately faxes both pages to the attention of HR or President.		
	Name	Time & Date
Reported by:(Director or designee)		
Reported to: (HR or President)		
Written report faxed:		
HR 651-407- 7174 ext.202. (If unavailable: President at ext. 203 or 651-332-6267) FAX 651-407-7181		

EMPLOYEE COMPLETES THIS SECTION:

Describe what you were doing before the incident and how the injury occurred. Include the initials of persons (staff and clients) involved and equipment used.

What was the injury or illness (include part(s) of the body)?

Have you experienced this type of injury in the past? No Yes - (answer question below)

Where: _____ When: _____

Are you currently working outside of Phoenix Alternatives? No Yes - (answer questions below)

Employer Name: _____

Job Title: _____

Full Employer Address: _____

How many hours are you working per week at this job? _____

Employee Signature: _____ Date: _____

EMPLOYEE AND REPORTING MANAGER COMPLETES THIS SECTION:

<p align="center">Medical care follow-up</p> <p><i>Complete only if employee waits on medical care decision:</i></p> <p><input type="checkbox"/> No further action</p> <p><input type="checkbox"/> Medical care requested</p> <p>Appt Date: _____</p>
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This Incident is related to: (check all that apply)

- An injury of undetermined severity
- A serious injury; employee requires emergency care or hospitalization.
- Work related fatality or in-patient hospitalization of three or more employees.

Is the employee requesting medical care?

Employees may use the Occupational Health Provider, call 911 (for emergencies), or they may see their own health care provider. Employees may also choose not to have medical care.

- Employee is requesting medical care at this time. Appointment date/time _____
- Employee requires or is requesting emergency medical care.
- Employee does not want medical care.
- Employee would like to wait to evaluate if they need medical care until the next working day.

(If the wait option is selected, continue to forward this form even though the decision for medical care is undecided. On the next working day, put the employee's updated response in the box above and re-fax the form.)

Was this incident preventable?

- No
- Yes

Comments:

Describe what can be done to prevent this type of injury?

Document any prevention strategies, who will follow up and when.

Was there an exchange of blood?

- No (skip questions below)
- Yes (answer questions below)

Has the employee had the Hepatitis B vaccination series?

- No, offer the Hepatitis B vaccine. Does the employee wish to receive it? Yes No
- Yes, does the employee wish to have a blood titer drawn to check their vaccine level? Yes No

Coordinator or Designee Signature/ Date

Director Signature / Date

HR or designee will report work related incidents of fatalities or in-patient hospitalization of three or more employees to OSHA within eight hours.