Incident Report / TREATMENT SOUGHT

This form must be completed each time an Injury or accident occurs in which the employee states he/she was injured and wishes to seek medical treatment. This must be turned In to the Safety & Health Coordinator/HR within 24 hours of being reported. A Worker's Compensation Claim must be reported, along with this Accident Investigation Report, and it should be attached and submitted to the insurer along with the First Report of Injury for reporting to the State.

Part I – Employee Information

Employee Name:	Department:	Shift:

Part II – Accident Data

Date of Incident or Injury:			Who was the supervisor/manager this was reported to?
Time:	☐ Am ☐ Pm		
At this time does not require medical treatment? ☐ ok if you agree			Witnesses? Please list names.

List the BUILDING AREA where the incident happened:

List the NATURE of the injury (example – burn, sprain, cut, etc.):

Tell what HAPPENED (include job(s), part name, equipment, tools or products that were involved)

(if this injury has occurred over a duration of time – list the jobs you have been doing and for how long)

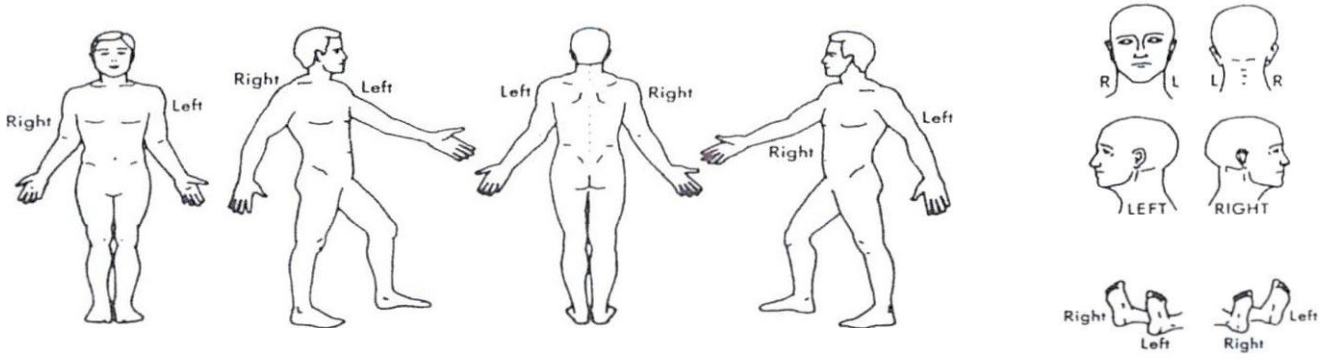
Did the incident or injury involve any other personnel? ☐ Yes ☐ No

If yes, please describe:

Part III – Location of discomfort/pain

List all Body Parts that are injured or hurting (for example – right wrist, lower back, left arm):

Please circle or mark on the drawing the location of your pain.



Part IV – Description of Pain

Please check all that apply. If none of these words describe the pain correctly, please use your own words in the comment section.

☐ Sharp ☐ Numbness ☐ Shooting	☐ Ache ☐ Constant	☐ Dull ☐ Throb	☐ Burning ☐ Positional	☐ Tingling ☐ Weakness	☐ Prick ☐ Cramping	☐ Pull ☐ Intermittent	☐ Pressure ☐ Stiffness

COMMENTS:

Part V – Intensity of Pain		1	2	3	4	5	6	7	8	9	10	
Rate your pain RIGHT NOW.	No Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst Pain
Rate your pain at its WORST.	No Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst Pain
Rate your pain at its BEST.	No Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst Pain

Part VI – Onset/Duration of Pain

A. When did you first notice the pain?

B. What makes the pain better?

C. What makes the pain worse?

D. Are there any other effects of the pain? For example: difficulty sleeping, becoming nauseated, and difficulty doing ordinary tasks. Please describe.

Only complete this form if you feel the injury or symptoms are work-related in nature. You must complete this form with your supervisor – (or backup supervisory personnel),

EMPLOYEE SIGNATURE:	DATE:
SIGNATURE OF SUPERVISOR COMPLETING REPORT WITH EMPLOYEE:	DATE: