Milford Regional Medical Center

MRMC/ATLANTIC CHARTER INSURANCE GROUP

EMPLOYEE INCIDENT REPORT

THIS REPORT MUST BE COMPLETED BY BOTH EMPLOYEE & SUPERVISOR WITHIN 24 HOURS OF INCIDENT

WORKER COMP. INSURANCE COMPANY: Atlantic Charter • 25 New Chardon St • Boston, MA 02114-4721 • Ph: 617-488-6500 • Fax: 617-488-6502

1. EMPLOYER INFORMATION: CHOOSE A LOCATION THAT MOST CLOSELY REPRESENTS YOUR EMPLOYER

	LOCATION:	ADDRESS:	PHONE #:
❒	MRMC	14 Prospect Street, Milford, MA 01757	508-473-1190
❒	TCMA	9 Industrial Road, Milford, MA 01757	508-473-1480

EH OFFICE USE ONLY:
LOCATION CODE
_____
_____

2. EMPLOYEE INFORMATION: EMPLOYEE & SUPERVISOR COMPLETE THE EMPLOYEE INFO. TO THE BEST OF THEIR KNOWLEDGE

Name: _____ Job Title: _____ Job Code: _____
DOB: _____ Social Security #: _____ Date of Hire: _____
Department Name: _____ Shift: _____ Department Code: _____
Status: ❒ Active: # *scheduled* days per week:_____ ❒ On Call: # days per week (*on average*): _____
Home: Street: _____ City: _____ State: _____ Zip Code: _____
Phone: Home: _____ Cell: _____ Work: _____

3. EMPLOYEE'S STATEMENT: EMPLOYEE DESCRIBES THE INCIDENT

Incident Date: _____ Time of Incident: _____ ❒AM ❒PM Time shift began: _____ ❒AM ❒PM
Location of Incident (Be *very* specific): _____
If a patient was involved in the incident, please provide their Med. Record #: _____
Part of body injured (Be specific: Right, Left, etc.): _____
Name of Supervisor notified of incident: _____
Was there a witness to the incident? ❒Yes ❒No ❒Unsure
If "yes": Name of witness: _____ Phone #: _____
Name of witness: _____ Phone #: _____

DESCRIPTION OF INCIDENT (WHAT HAPPENED?) **MUST BE WRITTEN & SIGNED BY THE EMPLOYEE**

_____
_____
_____
_____

I authorize the release of all medical information without limitation, including, but not limited to, history, findings, diagnosis, prognosis and access to all treatment records for examination and photocopying to Charter Management Company, Inc., Atlantic Charter Insurance Company and Sallop and Weisman P.C. I authorize that a photocopy of this form be accepted with the same authority as the original. Please be advised that pursuant to 45 CFR 164.512(I), the HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies or employers. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation system to have access to an individual's health information as authorized by state or other law.

_____ _____
EMPLOYEE SIGNATURE **Date**

4. SUPERVISOR'S STATEMENT: I HAVE REVIEWED THIS REPORT WITH THE EMPLOYEE

Did employee receive medical attention for this injury? ❒Yes ❒No ❒Unsure
If "yes": Physician/Hospital Name & Address: _____
Date of initial treatment: _____
Has employee returned to work since the incident? ❒Yes ❒No ❒Unsure
If "yes": Date returned to work: _____ *Describe:* ❒ Full/Regular Duty ❒ Transitional (Light) Duty
If "no": Last Date worked: _____ *Describe:* ❒Full Day or ❒Partial Day: # hours: _____
First full day absent (*cannot be the date of the incident*): _____

_____ _____
SUPERVISOR SIGNATURE **Date**

This report MUST BE FAXED to Employee Health within 24 hours of incident (EH FAX: 508-634-8732)

COMPLETE THE SUPERVISOR'S INVESTIGATIVE REPORT (page 2)

Milford Regional Medical Center

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SUPERVISOR'S INVESTIGATIVE REPORT

The completion of this form will help us to eliminate job hindrances that interrupt or interfere with the orderly progress of the job.

SUPERVISOR: Please complete *all* of the following questions *with the injured employee* & fax it to Employee Health (508-634-8732) with the Incident Report.

Employee Name: _____

Job Title: _____ Department: _____

Date/Time of Incident: _____ Date/Time Incident Reported: _____

Was report delayed? ❒No ❒Yes: *Please note brief reason why report was delayed:* _____

_____

1. WHAT HAPPENED? (Describe what took place/what caused you to investigate this incident)

_____

_____

a. Was this a task that the employee performs regularly? ❒Yes ❒No ❒Unsure
If "yes", what was different about this particular time that caused the injury? _____

_____

If "no", what was the reason this employee was performing this task? _____

_____

2. WHY DID IT HAPPEN? (Define the *essential cause* of the injury) (check all that apply)

❒ *Material/Equipment* (i.e.: equipment failure, didn't have the right tool/equipment, equipment not available)
Describe in detail: _____

_____

If injury is a blood/body fluid exposure related to a sharp medical device:

Was device part of pre-packaged kit? ❒ Yes ❒ No
Manufacturer of Device: _____
Brand of Device: _____
Model of Device (size/gauge): _____

Does it have a safety feature? ❒ Yes ❒ No
Describe safety feature: _____

_____

❒ *Environment* (i.e.: black ice, improper lighting, wet floor, crowded room)
Describe in detail: _____

_____

❒ *Human error* (i.e.: dropped piece of equipment, bumped into wall, tripped over own feet)
Describe in detail: _____

_____

PLEASE NOTE: QUESTIONS 3 & 4 MUST BE COMPLETED WITH ANSWERS OTHER THAN "NOTHING" & "NONE"

3. WHAT SHOULD BE DONE TO ENSURE THAT THIS INJURY DOES NOT OCCUR AGAIN?

_____

_____

4. WHAT ACTIONS HAVE YOU TAKEN THUS FAR? (i.e.: retrained, equipment changes, procedural changes, personal protective equipment, contacted key personnel)

_____

_____

Additional comments may be added on the back of this form.

_____ _____

Supervisor Signature **Date**

PLEASE FAX THIS FORM TO EMPLOYEE HEALTH (508-634-8732) ASAP.

This form may be reviewed at the next scheduled Environment of Care meeting.

For EH use only: Review at EOC? ❒ Yes ❒ No