 Employee Accident Incident Report

269 Bates Street, Lewiston, ME 04240P: (207) 795-4040 F: (207) 795-4044

TO: Human Resources

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| 1. LAST NAME: | | | | | | | FIRST NAME: | | | | | | | | | M.I.: | | | | | | | 2. S.S.N.: | | | |
| 3. ADDRESS – NUMBER & STREET: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. CITY: | | | | | | | | | | | STATE: | | | | | | | | | ZIP CODE: | | | | | | |
| 5. HOME PHONE: | | | | | | 6. DATE OF BIRTH: | | | | | | | | | 7. AGE: | | | | | | | | 8. SEX: MALE | | | |
| FEMALE | |  |  |
| 9. OCCUPATION: | | | | | 10. DEPARTMENT: | | | | | | | | | | | | 11. LOCATION (If different from mailing address): | | | | | | | | | |
| 12. CENTER PHONE NUMBER: | | | | | | | | | | | | | 13. TIME EMPLOYEE’S DAY BEGAN: | | | | | | | | | | | | | |
| 14. DATE OF HIRE: | | | | | | 15. DATE CURRENT DUTIES BEGAN: | | | | | | | | | | | | | | | | 16. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER:  YES NO | | | | |
| 17. WEEKLY WAGE AT TIME OF INJURY: | | | | | | | | | 18. POLICY NUMBER: #1810006774 | | | | | | | | | | | | INSURER NUMBER: | | | | | |
| INJURY OR EXPOSURE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. DATE AND TIME OF INJURY: | | | | 20. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER’S PREMISES? | | | | | | | | | | 21. IF NO, PLACE WHERE INJURY OR EXPOSURE OCCURRED: | | | | | | | | | | | | |
|  | AM | | | YES | | | | | | NO | | | |
| PM |  |  |
| 22. DESCRIBE THE EVENTS WHICH RESULTED IN THE INJURY OR DISEASE. (GIVE FULL DETAILS ON ALL FACTORS THAT LED OR CONTRIBUTED TO THE INJURY OR THE ONSET OF DISEASE.)  WAS THERE BLOOD PRESENT?  IF YES, WAS ANYONE ELSE EXPOSED TO THE BLOOD? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23. NAME THE OBJECT, SUBSTANCE, OR EXPOSURE WHICH DIRECTLY BROUGHT ABOUT THE INJURY OR DISEASE. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. DESCRIBE THE INJURY OR DISEASE AND INDICATE PART OF THE BODY AFFECTED. (I.E. BITE, CUT, SCRAPE, EYE INJURY, SPRAIN, BURN, HEAD INJURY, BROKEN BONE, SLIVER, BRUISE FOREIGN BODY, STING, CHOKING, POISONING, ETC.)  ACTION TAKEN /TREATMENT REQUIRED: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. PHYSICIAN (NAME & ADDRESS): | | | | | | | | 26. | | | | FIRST AID | | | | | | 27. HOSPITAL (NAME & ADDRESS): | | | | | | | | |
|  | | | | HOSPITAL | | | | | |
|  | | | | EMERGENCY ROOM | | | | | |
|  | | | | OUTPATIENT | | | | | |
| 28. MUST FILL OUT: LOOKING BACK, HOW COULD THE ABOVE INJURY HAVE BEEN PREVENTED? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29. WHO WITNESSED THE INJURY? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. SIGNATURE OF WITNESS(ES): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNATURE OF PERSON MAKING REPORT: | | | | | | | | | | | | | | | | | | | DATE: | | | | | | | |
| SIGNATURE OF IMMEDIATE SUPERVISOR: | | | | | | | | | | | | | | | | | | | DATE: | | | | | | | |
| DATE EMPLOYER NOTIFIED: | | | | | | | | EMPLOYER FILE NUMBER: | | | | | | | | | | | | | | | |  | | |

**REQUIRED- CALL HR IMMEDIATLEY** (within 1 hour of incident) 207-795-4040 ext 313 or 300

CC: Employee

Health Manager Employee’s Manager

08.01.2022 khg