MRCI CLIENT DIRECTED SERVICES

# INCIDENT/ ACCIDENT REPORT FORM

**Use black ink - NO WHITEOUT**

**Section 1- Completed by Employee/ Worker**

Legal Name of Person Involved: _____ Date of Report: _____

Date of Incident/ Accident: _____ Time of Incident/ Accident: _____ am/pm

Witnesses: Name _____ Phone: (_____)_____

Name _____ Phone: (_____)_____

Specific Location and Address of Accident/Injury:_____

**INCIDENT/ACCIDENT**

Describe the incident/accident. Use facts and specific detail to describe the incident. (Include what was happening prior to the incident, response to the incident and effect on the person):

_____

_____

_____

_____

**Action taken to prevent re-occurrence:**

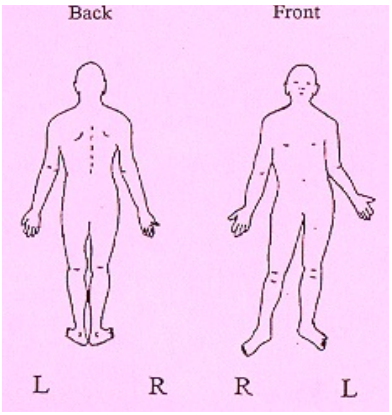
_____

_____

_____

**INJURIES** ☐ **Yes** ☐ **No** ****** If there are *NO* injuries, please go to Section 3 and 4, if applicable. If injury requires *outside* medical attention please call Human Resources immediately and fill out Section 2.**

Circle site of injury:




Nature of Injury:

☐ Arrived with Injury ☐ Abrasion

☐ Bite ☐ Burn

☐ Bruise(s) ☐ Cut/Laceration Puncture

☐ Other _____

Identify First Aid Provided: _____

Does injury require medical attention (tetanus shot, stitches, etc.)? ☐ Yes ☐ No

Was blood or OPIM present? ☐ Yes ☐ No

Did the First Aid Provider wear gloves? ☐ Yes ☐ No

First Aid Provider: ☐ self ☐ Other _____

**EXPOSURE INCIDENT**

This ☐ is ☐ is not an exposure incident. **If it is, contact MRCI immediately at 1-800-829-7110 for further instructions.**

Health Care Professional notified immediately and Exposure Incident Report form completed ☐ N/A ☐ Yes

By Whom: _____ Date:_____

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# INCIDENT/ ACCIDENT REPORT FORM- Continued

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**Section 2 - Completed by Employee/ Worker or Supervisor ONLY if incident/accident involved outside medical treatment**

**OUTSIDE MEDICAL TREATMENT** * Please send any doctor's notes or medical treatment regarding this injury to H.R.*

Date of Initial Visit to Medical Provider:_____ Name of Treating Physician/Name of Facility: _____

Address of Facility: _____

Time Employee began work on day of injury: _____ Date of First Day of Lost Time: _____

Supervisor who first received knowledge of injury _____

Date Returned to Work: _____ Please describe injured employee's normal work schedule: _____

**Section 3 – Please Sign**

**SIGNATURES**

_____ _____

Signature and Title of Person Completing form Date Signature of Supervisor/Team Leader/Counselor Date

_____ _____

Signature of Program Manager Date Signature of Safety Coordinator Date

Safety & Health Investigation completed: ☐ Yes ☐ No