The Indiana Hand Center

ASSOCIATE INCIDENT REPORT

An incident is any "happening", with or without injury, occasioned by an employee.

Date:_____

Person Involved

Last Name:	First	Middle:
Occupation/Job Title:		
Address (include zip)		Marital Status: ___ Unmarried ___ Married ___ Separated ___ Unknown
Date of Birth:	Sex: Male_____ Female _____	Social Security Number:
Phone Number:	Date of Hire:	# of Dependants:

Occurrence/Treatment Information

Date of Injury/Exposure:	Time of Occurrence:
Part of Body:	Type of Injury/Exposure:
Department or Location where accident/exposure occurred:	
Specific Activity Engaged in During Accident/Exposure:	
Work Process Employee Engaged in During Accident/Exposure	
How Injury/Exposure Occurred. Describe the Sequence of Events and Include any Relevant Objects or Substances:	
Name of Physician/Health Care Provider	
Was employee using Universal Precautions?	
Did testing take place?	Date:

Witness to Incident: (Please Indicate if patient, visitor, or associate)

Name: Address: Phone:	Name: Address: Phone:

Incident Reported By:	Date:
Signed:	
Report Prepared By:	Date:
Incident Investigated By:	Date:

Incident Reviewed by Executive Director:_____ Date:_____

Incident Reviewed By Quality Assurance Committee-Quality Assurance Committee Action/Recommendations:

_____

_____

Date:_____

Follow-up Required: _____

_____

_____

THIS REPORT SHOULD BE COMPLETED IMMEDIATELY (NO LATER THAN 24 HOURS) AFTER AN INCIDENT AND SENT TO THE HUMAN RESOURCES MANAGER