Home Health Care Solutions
Employee Incident/Accident Report

Employee Name _____ Dept._____

Date of injury _____ Time _____ A.M. /P.M

Where did the injury take place? _____

Detail description of what happened **as stated** by the injured employee.

_____

_____

_____

_____

_____

_____

Witness _____

Type of injury:

Laceration ___ Contusion ___ Abrasion ___ Burn ___ Fracture ___ Eye ___

Strain/Sprain ___ Allergic ___ Inhalation ___ Puncture ___ Other ___

Part of the body involved _____

If applicable, right or left side _____

First Aide Assessment by Nurse:

_____

_____

_____

_____

Did the employee leave the facility for (approved) additional medical treatment? Yes ___ No ___

Was a company policy and/or procedure not used which could have led to this incident? No ___ yes, explain

_____

Employee Signature _____ Date _____

Nurse Signature _____ Date _____

Supervisor Signature _____ Date _____

Administrator Signature_____ Date _____

Important! If employee needs medical treatment outside of the facility, make a copy of this completed form for Human Resources immediately.