Montefiore | Nyack
160 North Midland Avenue
Nyack, New York 10960
(845) 348-2000

CORVEL

Employee Incident Report Form

To be completed by the Employee:	[ ] Injury [ ] Near Miss		
Employee Name (Last, First and Middle Initial)	Department	Date of Birth	Sex [ ] M [ ] F
Home Address (Street or PO Box)	Employee Status: (FT/ PT/ Per diem)	Position Title	
City State Zip	Home Telephone Number	Work ext.	Date of Hire
Exact Location of Event	Specific Area/ Equipment	Job Being Performed During Event	

Description of Accident (What happened, specifically what was injured, how and why):

_____

_____

_____

_____

Employee must call (800) 683-6778, Option1, and report to Corvel 24/7 Nurse Triage!

Witness Name: _____ Phone Number: _____ Department: _____

Employee Signature:_____ Date: _____

To Be Completed by Supervisor:

Injured: Date Time	Reported: Date Time	Time in Job Position: Years Months	Was Employee Working Overtime? [ ] Yes [ ] No [ ] N/A

If Accident, resulted in: [ ] Injury [ ] Illness [ ] Property Damage
If Near Miss, could have resulted in: [ ] Injury [ ] Illness [ ] Property Damage

Type of Incident (choose one)

[ ] Allergic Reaction
[ ] Back Injury
[ ] Banged into Object
[ ] Bitten by Animal/ Insect/ Person
[ ] Burn
[ ] Chemical Exposure
[ ] Cut: Non Exposure
[ ] Exposure to Infectious Disease
[ ] Other Injury Related to Patient Care _____
[ ] Fall
[ ] Foreign Body in Eye
[ ] Inhalation of Odor/ Fume
[ ] Motor Vehicle Accident
[ ] Object Fell on Employee
[ ] Repetitive Motion Injury
[ ] Sharps Injury
[ ] Other _____

Blood/ Body Fluid Exposure:

[ ] Bite/ Scratch
[ ] Blood
[ ] Body Fluid

Employee Exposure Report must also be completed.

Exposed Area:

[ ] Eye
[ ] Open Cut
[ ] Other _____

Sharps Injury/ Exposure:

[ ] Butterfly
[ ] Razor
[ ] IV Stylet
[ ] Phlebotomy Needle/ Vacutainer
[ ] Scalpel
[ ] Lancet
[ ] Suture Needle
[ ] Other _____

To Be Completed by Employee Health Services/ Human Resources:

Treatment Provided/Recommendations:

_____

_____

_____

Employee Health Services/ HR Signature: Date:

THIS FORM IS TO BE COMPLETED AND RETURNED TO HUMAN RESOURCES WITHIN 24 HOURS OF THE INCIDENT.
HUMAN RESOURCES FAX # 845-348-3045.

Claims may also be reported via fax: 1-866-777-1668

CLAIMS REPORTED VIA FAX MUST BE RECEIVED WITHIN 24 HOURS OF THE INCIDENT

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Part 2 Accident Description and Direct Cause Analysis

To Be Completed by Supervisor:

Employee's Name:	**Date of Incident:**

What Occurred: Describe Sequence 1. Background Information 2. Employee's location and position relative to immediate surroundings 3. How employee was performing their job 4. What occurred that precipitated the accident 5. Type of accident

_____
_____
_____
_____
_____

Employee To: [ ] HOME [ ] ED [ ] PMD [ ] REFUSED MEDICAL TREATMENT [ ] EMPLOYEE HEALTH

What may have been contributing actions:	**What may have been contributing conditions:**
[ ] Poor body mechanics	[ ] Inadequate guard/ safety device
[ ] Nullified safety device	[ ] Needed additional assistance
[ ] Improper use of safety device	[ ] Lift device not used
[ ] Operating w/o training	[ ] Hazardous attire/ condition/ storage
[ ] Used equipment un-safely	[ ] Defective tools/ equipment
[ ] Combative Patient	[ ] Illumination/ noise hazard
[ ] Used wrong or defective Equipment	[ ] Protruding object hazard
[ ] Tried to gain/ save time	[ ] Atmospheric condition
[ ] Inadequate PPE	[ ] Ice/ Snow Outside
[ ] Standard procedure deviation	[ ] Defective from normal use
[ ] Unaware/ inattention to job hazard	[ ] Management approval
[ ] Influenced by distraction	[ ] Inadequate safety inspection
[ ] Unaware of safe method	[ ] Inadequate housekeeping/ clean-up
[ ] Influence of illness or fatigue	[ ] Inadequate Preventative Maintenance
[ ] Other _____	[ ] Other _____
[ ] No unsafe action	[ ] No unsafe condition

What action has been taken or planned to prevent recurrence?	**Person Responsible:**	**Target Date for Completion:**
[ ] Consult Maintenance [ ] Eliminate Congestion [ ] Improved Enforcement [ ] Re-educate employee involved [ ] Repair/ replace equipment [ ] Require protective equipment [ ] Request Ergonomic Evaluation [ ] Mandatory pre-job instructions [ ] Job reassignment of employee [ ] Improved Inspection procedure [ ] Preventative instruction of others doing job [ ] Investigate/ implement safety guard/ device [ ] Warning/ Discipline of Employees Involved		
Supervisor (Last Name, First Name)	Supervisor Signature	Date Completed

Has the cause of the incident been addressed/corrected? [ ] Yes [ ] No
If no, please forward to the Safety Officer!

To Be Completed by Human Resources:

Disposition:		**Case Type:**	
[ ] Return to Work without restrictions	[ ] Referred to ER or PMD	1. First Aid	4. Lost Work Day
[ ] Return to work with restrictions	[ ]Investigate Temporary Job Transfer	2. Medical Treatment	5. Injury-Free
[ ] Sent home	[ ] Other: _____	3. Restricted Work	6. OSHA Recordable