



**NEW HAVEN YOUTH AND FAMILY SERVICES, INC.
EMPLOYEE INCIDENT/INJURY REPORT**

INITIAL REPORT – THIS PAGE TO BE COMPLETED BY EMPLOYEE.

STAFF NAME:		SSN:	DOB:
HOME PHONE:		WORK PHONE:	
HOME ADDRESS:			
JOB TITLE:			DATE OF HIRE:
# OF HOURS WORKED PER DAY:	# OF DAYS WORKED PER WEEK:	TOTAL HOURS WORKED PER WEEK:	
EMPLOYMENT CLASSIFICATION: (CIRCLE ONE): FT PT ON-CALL		WAGE: \$ _____ PER	
DATE OF INCIDENT/INJURY:	TIME OF INCIDENT/INJURY:	TIME WORK BEGAN:	
LOCATION INCIDENT/INJURY OCCURRED (ADDRESS):			
DESCRIBE THE INCIDENT/ACCIDENT IN DETAIL (WHO, WHAT, WHEN, WHERE, HOW):			
CIRCLE ONE: A. INJURY INVOLVED B. INCIDENT REPORTED NO INJURY INVOLVED			
DESCRIBE THE INJURY (PART OF BODY EFFECTED, ETC.):			
EMPLOYEE SIGNATURE:		DATE:	TIME:

If you are not obtaining treatment at this time, please note why here:

- Do not feel necessary*
 Do not know where to go or what to do**
 Do not have time**
 Other:

**Please report to HR if this status changes and/or your supervisor disagrees, **See HR*

HUMAN RESOURCES/SUPERVISOR'S INVESTIGATION

WITNESSES (ATTACH WRITTEN STATEMENTS):

1.	2.
3.	4.

DESCRIBE THE INCIDENT/INJURY (OBSERVE THE SITE, ASK QUESTIONS, DETERMINE FACTS):

INCIDENT/INJURY CAUSES (CHECK ALL THAT APPLY):

<input type="checkbox"/> Inability <input type="checkbox"/> Willful Violation <input type="checkbox"/> Inadequate Training <input type="checkbox"/> Lacked Understanding <input type="checkbox"/> Poor Body Mechanics <input type="checkbox"/> Defects in equipment <input type="checkbox"/> Unknown Defects/Hazards in Environment	<input type="checkbox"/> Misguided Clearance/Motion <input type="checkbox"/> Misuses of Equipment/Materials <input type="checkbox"/> Wrong Attitude/Poor Judgment <input type="checkbox"/> Poor Housekeeping/Clutter/Lack of Order <input type="checkbox"/> Inattention <input type="checkbox"/> Incident result of Client Behaviors <input type="checkbox"/> Incident result of Factors that Could Not Have Been Reasonably Anticipated
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COMMENTS:

CORRECTIVE ACTION(S) REQUIRED FOR PREMISES & EQUIPMENT (IDENTIFY & LIST):

CORRECTIVE ACTION(S) REQUIRED FOR EMPLOYEE AND TARGET DATE FOR COMPLETION:

<input type="checkbox"/> Repeat Training <input type="checkbox"/> Verbal Warning <input type="checkbox"/> Suspension	<input type="checkbox"/> Restricted Work <input type="checkbox"/> Employee Counseled/No Further Action Required At This Time
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COMMENTS:

MEDICAL TREATMENT – TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT

CHECK ONE: <input type="checkbox"/> FIRST AID ONLY – NOT OSHA RECORDABLE <input type="checkbox"/> WORK COMP – OSHA RECORDABLE	NAME/ADDRESS IF OTHER PHYSICIAN SEEN:
<input type="checkbox"/> YES <input type="checkbox"/> NO – WILL THERE BE WORK TIME MISSED? IF YES, HOW MANY DAYS? _____ <input type="checkbox"/> YES <input type="checkbox"/> NO – ARE THERE WORK RESTRICTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO – PRESCRIPTION MEDICATION PRESCRIBED? <input type="checkbox"/> YES <input type="checkbox"/> NO – ARE THERE ANY PRE-EXISTING CONDITIONS/INJURIES? _____	

SIGNATURES:

SUPERVISOR/PROGRAM DIRECTOR SIGNATURE:		DATE:
HUMAN RESOURCES DIRECTOR SIGNATURE:		DATE: