PROVIDENCE Health & Services

Non-Employee Injury/Incident Report

Non-Employee Information - As Applicable

Name		ID Number
Home Address		City, State
Home Telephone Number		Gender
Hire Date		Date of Birth
Job Title	Home Department	Department Number
Facility	Location of Incident	Manager
Date of Incident	Time of Incident	Time began work _____:_____ ☐ am ☐ pm

Provider Information

Was medical treatment sought? ☐ Yes ☐ No Was treatment provided in ER? ☐ Yes ☐ No Hospitalized overnight? ☐ Yes ☐ No

Name of Treatment Provider:

Was medical treatment given away from the worksite? ☐ Yes ☐ No If Yes, indicate Facility, Street, City & State on next line.

Facility Street City, State

Incident Information

*Select one code from each group that **BEST** describes the injury/incident. Note additional information in narrative space below.*

Accident Cause (*select one*)

Blood or Body Fluid Exposure
- ☐ Human Bite / Scratch
- ☐ Sharp / Needle
- ☐ Splash

Workplace Violence
- ☐ Coworker
- ☐ Patient / Client / Visitor
- ☐ Stranger
- ☐ Personal Relation

Fall/Slip/Trip Injury ***(select wet or dry)***
- ☐ From Different Level ☐ Wet surface
- ☐ From Same Level ☐ Dry surface

Struck by or against
- ☐ Person (Unintentional) ☐ Stationary Object
- ☐ Equipment
- ☐ Moving Object

Strain/Sprain
- ☐ Twisting
- ☐ Lifting
- ☐ Pushing / Pulling
- ☐ Holding / Carrying
- ☐ Reaching
- ☐ Repetitive Motion

Exposure to:
- ☐ Chemicals
- ☐ Extreme Heat or Cold
- ☐ Electricity
- ☐ Noise
- ☐ Radiation
- ☐ Communicable Disease
- ☐ Odor
- ☐ Latex
- ☐ Dust / Dander
- ☐ Building Temperature / Air

Miscellaneous
- ☐ Animal or Insect Bite
- ☐ Foreign Body
- ☐ Stress
- ☐ **Caught In or Between** ____________
- ☐ **Cut /Punc /Scrape Inj By** ____________
- ☐ **Motor Vehicle**
- ☐ **Unsafe Condition**

Body Part

Select one
- ☐ No body part injured
- ☐ Left ☐ Right
- ☐ Both ☐ Not Applicable

Select primary *(Write additional parts in narrative space below.)*
- ☐ Eye ☐ Chest
- ☐ Face ☐ Upper Respiratory
- ☐ Head ☐ Lungs
- ☐ Neck ☐ Abdomen / Pelvis
- ☐ Back ☐ Buttocks / Hip
- ☐ Shoulder ☐ Leg
- ☐ Arm ☐ Knee
- ☐ Elbow ☐ Ankle
- ☐ Wrist ☐ Foot
- ☐ Hand ☐ Toe
- ☐ Finger ☐ Mental / Emotional

Accident Result (*select one*)

- ☐ Amputation ☐ Headache
- ☐ Burn or Freezing ☐ Hearing Impairment
- ☐ Contusion ☐ Heat Stroke / Exhaustion
- ☐ Concussion ☐ Hernia
- ☐ Crushing ☐ Laceration
- ☐ Dermatitis / Rash / Hives ☐ Puncture
- ☐ Dislocation ☐ Nausea / Vomiting
- ☐ Electric Shock ☐ Sprain / Strain
- ☐ Loss of Eye(s) ☐ Respiratory Distress
- ☐ Foreign Body ☐ Vision Impairment
- ☐ Fracture ☐ Mental Stress

- ☐ Occupational Illness ____________
- ☐ Contagious Disease ____________
- ☐ Repetitive Motion ____________
- ☐ **Death** ____________
- ☐ **No Injury/Near Miss**

Did patient action / condition contribute? ☐ Yes ☐ No

What was the caregiver doing just before the incident occurred?

What happened ? Tell how the incident occurred include contributing factors.

What object or substance directly harmed the caregiver? ____________

Caregiver Signature Date

Facility Representative

OSHA Recordable? ☐ Yes ☐ No Case # from OSHA Log ____________

Notify state OSHA of death or hospitalization as per state requirements

☐ Accident Investigation Report with copy of this completed form sent to:

____

☐ Employee was provided a copy of this completed report.

Comments: ____________

Completed by ____________ Phone: ____________

Title Date

Please forward to Caregiver (Employee) Health