Injury / Incident Form

TO BE COMPLETED BY THE SUPERVISOR OR DEPARTMENT MANGER

Reporting an Incident:

Operating Company: ____________________________
Job Name: ____________________________
Job Number: ____________________________

Who Was Injured?

Injured Employee Name: ________________________
Date of Injury: ______/______/______
Date of Birth: ______/______/______
Address of Injury: ________________________________
City, State, Zip: __________________________________

Describe what happened & location on jobsite where accident occurred:
____
____
____

Part of Body Injured: ____

Direct Cause of Injury: (*This is the object, substance, exposure, or bodily motion, which directly contributed to the injury.)*
____
____
____
____

Was there a pre-task plan for the day's activity? Yes / No – (*If yes please provide with this document.)*

Lessons learned by employee/management to be completed after investigation:
____
____
____

When Did It Happen:

Date Injury was Reported: ____/____/______
Date of Injury: ____/____/______
Time Injury Reported to Supervisor/Manager (AM/PM)_________________
Time of Injury (Include AM or PM): ________________ Time Injury was Reported to Safety Department (AM/PM)_______________

Classification of Employee: _________________________

Foreman/Supervisor: ___________________ Superintendent/Project Manager: __________________Other______________________

Witness

Name and Phone Number: ___________________________ _____________________
Name and Phone Number: ___________________________ _____________________

Form Completed By:______________________ **Title:**__________________ **Phone:**______________ **Date Completed:** _____/____/_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION - TO BE COMPLETED BY INJURED

I, _________________________________ (Injured) employed by __________________________ authorize the physician (s), hospital, medical attendant(s), nurse(s) or others involved in my treatment and care to release to National Fire & Safety or its agent, any and all medical records, reports, test results, nurses' notes, physician's notes, billing statements, doctors diagnosis, and all other information or opinions which have been, are being or will be generated, regarding my treatment or condition as a result of injuries I suffered in an accident which occurred on:

____________________, 20___, at ______ AM / PM

It is my understanding that the purpose of the use and disclosure of the protected health information requested and authorized hereunder is for use by National Fire & Safety and/or its insurance carrier for the evaluation and processing of my **potential workers' compensation claim**.

It is my understanding there is a potential that the protected health information or medical records disclosed to National Fire & Safety pursuant to this authorization may be re-disclosed and, thus, would no longer be protected under the Standards for Privacy of Individually Identifiable Health Information issued under the Health Insurance Portability and Accountability Act of 1996.

Signature: _________________________ Date: ___/____/_20____ Witness Signature____________________________ Date: ___/____/_20____