HR connection

Name ______________________________ **SS#** __ __ __ - __ __ - __ __ __ __
Last, First, Middle Initial (Please Print)

>>Report of Occupational Injury or Illness – Non-Employee Exposure

Directions:

- Complete Sections I, II and III.
- If the injured person is unable to complete this form, the on-duty supervisor or lead employee also completes Sections I and II (if needed).
- For a bloodborne pathogen exposure, call your office OSHA Coordinator. You may report the exposure to Employee Health at (704) 355-2106. If after office hours, leave a voice mail message including name and phone number and also immediately notify the nursing supervisor on duty.

Section I – When, Where, and How

Date of Injury or diagnosis of occupational disease: __ __/__ __/__ __ __ __ Time: ______ AM/PM

Supervisor or lead employee name: ________________________ Time shift began: ________ AM/PM

When was supervisor or lead employee notified? Date: __ __/__ __/__ __ __ __ Time: ______ AM/PM

Physical location where injury or exposure occurred (Bldg./Floor/Wing/Room): ________________

Did the injury occur on CHS premises? ☐ Yes ☐ No

Was this the employee's usual work place? ☐ Yes ☐ No

Was medical treatment required? ☐ None ☐ First Aid only ☐ Treated at: ______________

Type of Instrument: Identify physical/mechanical objects involved (tools, supplies, equipment, structure, brand name, etc.): ____

____

Witness name: ______________________________ Telephone #: (_____) ______-__________

Section II – Complete for a Bloodborne Pathogen or Infectious Disease Exposure Only

Is the source known? ☐ Yes ☐ No If known: ☐ Not a patient ☐ Patient

Source name: ____

Patient History #:___________ Diagnosis: ________________________________

Type of exposure: ☐ Through broken skin ☐ Splash on skin ☐ Splash on mucous membrane ☐ Airborne

Section III – Injury Description (This must be completed by the injured person.)

Describe in detail how the injury occurred, activity at the time. List specific body part(s) injured & describe injury. (Attach additional sheet if necessary.): ________________________________

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I certify the information I have furnished on this form is true and accurate to the best of my knowledge.

Injured Person's Signature: ____________________________ **Date:** __ __ /__ __/__ __ __ __

Physician's Name: ____

Physician's Primary Work Site: ____

Company Name: ____

Office Contact Person: ____

Address: ____

Telephone Number: ____

Lead Employee/Supervisor Name: ________________________ **Date:** __ __ /__ __/__ __ __ __
(Please Print)

Lead Employee/Supervisor Signature: ________________________ **Telephone #:** __________

HUMAN RESOURCES

Carolinas HealthCare System