Einstein HEALTHCARE NETWORK

Employee Incident Report

Please print. Complete every item on form. *Date of Incident:* _____

Incident Location: ◯ MEDICAL CENTER PHILA (EMCP) ◯ LTSR ◯ GERMANTOWN ◯ WILLOWCREST BUILDING

◯ MEDICAL CENTER MONTGOMERY (EMCM) ◯ ELKINS PARK CAMPUS ◯ OTHER _____

INSTRUCTIONS:

1. **Employee must complete Section #1 and immediately forward entire report to supervisor.**
2. **Supervisors must complete Section #2. Original incident reports need to be sent to the OCCUPATIONAL HEALTH ADMINISTRATIVE OFFICE within 24 hours.**
3. **Questions – call the Occupational Health Administrative Office at 215-456-8142; fax # 215-456-7878.**
4. **A copy of the incident report needs to be brought to the medical provider (Emergency Department and/or the LiveWell Employee Health Center).**

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Section 1 – Employee

Name: _____ Social Security No.: _____-____-_____

Home Phone #: _____ Cell Phone #: _____ ◯ Male ◯ Female

Personal Email: _____

Home Address: _____ City/State/Zip Code _____

Date of Birth: _____ Date of Hire: _____ # of Hours per pay period: _____

Job Title: _____ Department: _____ Phone ext.: _____

Time of Incident: _____ ◯ AM ◯ PM Time began to work on day of incident: _____ ◯ AM ◯ PM

Time Shift Normally Ends: _____ ◯ AM ◯ PM On duty at Time of Incident: _____ Yes _____ No

Exact Location of Incident (**campus, building, floor, room number, etc**): _____

Incident Description: What were you doing at time of the incident?

_____

_____

What happened? _____

What body part was affected? _____

Needlestick/Sharps Incident - please provide source patient name, if known, room number, name of attending physician, and phone number of unit _____

What brand/manufacturer and type of sharps/needle product was used?_____

Name(s) of Witness(es): _____

Did you receive Medical Treatment? _____ If yes, name of medical provider: _____

Did you go to the Emergency Room? _____ If yes, where? _____

Employee's Signature: _____ Date: _____

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Section2 – Supervisor (Supervisor Investigation reports also need to be completed. They are available on Prism under Manager Self-service – Online Forms and Resources)

Did employee return to work? _____ If yes, when? _____ If no, contact Occupational Health

Supervisor's Name (Please print): _____ Phone Extension: _____

Supervisor's Signature: _____ Date Notified: _____