MSHN
Mid-State Health Network

INCIDENT REPORT FORM

Person Injured: ☐ Employee ☐ Consumer ☐ Visitor	
Employee Name:	**Incident Date & Time:**
Date and Time of Injury:	**Address Where Injury Occurred:**
***Consumer(s) Involved?** ☐ Yes ☐ No **Please do not include last name of consumer** ***(If "Yes," Attach copy of Incident Report.)**	**Was Place of Accident or Injury at Work Site?** ☐ Yes ☐ No
Other Employee(s) Involved and/or Present: Please have the other staff initial next to their name(s)	
How did the incident occur? Describe the activity and any equipment or materials you were using (Example: employee was opening a box of paper using an exacto knife; the exacto knife slipped on the corner of the box, and cut his/her right index finger):	
Did Employee Receive Treatment? ☐ Reporting Only (No Treatment Needed) ☐ Employee declined treatment at the time ☐ Treatment was Provided ☐ Treatment will be provided or sought	
Describe Treatment Provided (Example: Cut was washed; antiseptic and bandage were applied; stitches, etc.):	

Date & Time Care Given:	☐ **Injury Serious:** **(Requires Ambulance or Hospitalization)**	☐**Non-Serious**
If Serious, Date & Time Chief Executive Officer/Designee Notified:		
Was Employee Referred to Allegiance Occupational Health? ☐ Yes ☐ No		
Did the Health Care Professional Release Employee from Care? ☐ Yes ☐ No **Did the Health Care Professional Certify Employee for Disability Beyond the Work Day?** ☐ Yes ☐ No **(Must provide HR and Supervisor copy of Disability from Work Shift)**		

Supervisor's Recommendation (Administrative action to remedy and/or prevent recurrence of injury):

By signing this form, the employee certifies that the information the employee has provided is true to the best of his/her knowledge:

Employee Signature and Title	**Date and Time**
Supervisor Signature and Title	**Date and Time**

Original: Human Resources
cc: Employee's Supervisor
Facilities Manager

Follow up action(s), including date(s), taken by Facilities Manager: