

STAFF INCIDENT REPORT CONFIDENTIAL REPORT

HUMAN RESOURCES USE	MIDDLE GEORGIA FACILITY SYSTEM	SUPERVISOR'S USE
Facility Admin.	COLUMBUS, MILLEDGEVILLE, AND SAVANNAH, GEORGIA	Teleclaim operator:
Risk Mgmt.		Claim #:
Reimb. Comm.		Hire Date:
Infection Ctrl.		Salary:
		Lost Time:
	MANDATORY:	
	ALL INCIDENT REPORTS MUST BE RECEIVED IN	
	HUMAN RESOURCES WITHIN 48 HOURS OF THE INCIDENT.	

PART I: PERSONAL HISTORY (To be completed by STAFF)

NAME:		BIRTH DATE:		RACE:	SEX:
Home Address:			City/State:		Zip:
SS #:	Home Phone:	SHIFT	Begins:	Ends:	
Job Title:	Unit:	Extension:	Supervisor:		

PART II: INCIDENT INFORMATION (To be completed by STAFF)

DATE:	TIME:	LOCATION:
INCIDENT REPORTED TO:		DATE:
DESCRIBE THE INCIDENT & INJURY IN DETAIL (How, Where, Why):		

Witnesses:

STAFF SIGNATURE:	TITLE:	DATE:
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PART III: WORKERS' COMPENSATION SELECTION OF PAYMENT OPTION (To be completed by INJURED STAFF)

Select one of the following payment options in case lost time occurs:

(101) Workers' Compensation benefits for loss wages instead of using accrued leave. I understand I will be placed on leave without pay while I receive Workers' compensation benefits for loss of wages. I also understand that I will not receive full pay, but will be paid 66-2/3% of my average weekly wage, but not greater than \$350.00 weekly.

OR

(102) Use of my sick/annual and/or personal leave while absent due to my workers' Compensation injury and/or illness. I understand that if I use all of my accrued leave, I will receive Workers' Compensation benefits if I am still unable to work. I also understand that I cannot receive Workers' Compensation benefits and regular salary compensation (e.g., use of accrued leave) at the same time.

Entitlement of benefits for the first seven calendar days of disability or any portion of the time, requires that the employee be disabled for at least twenty-one consecutive calendar days and that the first seven calendar days were leave without pay.

I understand that all absences from work due to an injury and/or illness that qualifies as a serious health condition will be charged to available family leave.

STAFF SIGNATURE:	TITLE:	DATE:
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PART IV: CATEGORIES - Check the specific category (To be completed by Supervisor/Director)

INCIDENT:

Incident Caused By

TYPE

INJURY

EXACT BODY PART

(Specify Right/Left)

Staff: _____
 Patient: _____
 Visitor: _____
 Other: _____

Assault: _____
 Burn: _____
 A&D: _____
 Fall: _____

None: _____
 Bite: _____
 Bruise: _____
 Fracture: _____

Abdomen: _____
 Ankle: _____
 Back: _____
 Chest: _____

Victim

Staff: _____
 Patient: _____
 Visitor: _____

Injury: _____
 Property: _____
 Sexual: _____
 Vehicle: _____

Scratch: _____
 Swelling: _____
 Kick: _____
 Other (specify) _____

Eye: _____
 Face: _____
 Feet: _____
 Head: _____

Other: Pain

Knee: _____

Mouth: _____

Neck: _____

Total Number of Participants by Category, if Patient(s) are involved, supply Chart Number(s)

Staff: _____
 Patient: _____
 Visitor: _____

Chart #: _____
 Chart #: _____

Chart #: _____
 Chart #: _____

Shoulder: _____
 Hand: _____
 Other (specify) _____

PART V: COMMENTS AND ACTIONS (To be completed by Supervisor of Origin)

Employee was advised of Panel of Physicians (Y_) (N_)

Shift Completed (Y_) (N_)

Returned next day? (Y_) (N_)

Treatment selected (Y_) (N_)

If no, scheduled off (Y_) (N_)

Next scheduled day:

Employee selected treatment from:

The Georgia Activity Analysis Form should be sent to the doctor with the employee if treatment is selected.

First date aware of incident:

Number of Days STAFF Works/Week:

Additional training by SD&T for injury (Y_) (N_)

SIGNATURE:

TITLE:

DATE SIGNED:

PART VI: COMMENTS AND ACTIONS (To be completed by Approving Authority)

Reviewed and comments noted: additional comments:

SIGNATURE:

TITLE:

DATE SIGNED:

PART VI: COMMENTS (Please provide any additional information regarding the incident, i.e., weather conditions, environment, etc.)
