STOP–
Was employee sent to Physician?
❑ No ✓ Yes (If yes, complete the following) Name of physician

What specific act was responsible for this incident/accident?

What specific unsafe condition was responsible for this incident/accident?

Why does unsafe act/condition exist? (check one and explain below)
❑ Not applicable ❑ Lack of knowledge/experience
❑ Improper attitude ❑ Human limitation ❑ Other

What do you suggest be done to prevent a similar incident/accident? (check one and explain below)
❑ Training ❑ Instruction ❑ Repair/eliminate
❑ Reprimand ❑ Management recommendation

Corrective action taken

Signature and title of person completing report _______________ Date _______________

Review

Signature of administrator _______________ Date _______________

NOTE: To remove Part 1 (white copy), hold stub firmly and pull Part 1 only. This will allow Parts 2 & 3 to remain intact, providing duplicate records of the healthcare professionals written report.
# CONFIDENTIAL

## EMPLOYEE INCIDENT/ACCIDENT REPORT

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>ADDRESS</th>
</tr>
</thead>
</table>

**Employee Name, Title and/or Position**

<table>
<thead>
<tr>
<th>Length of Time in Position</th>
<th>Social Security #</th>
</tr>
</thead>
</table>

**Date/Time of Occurrence**

- [ ] AM / [ ] PM

**Specify Location/Site of Occurrence**

**Date Reported**

- [ ] / [ ] / 

Describe the actual circumstances under which the incident/accident occurred.

If anyone was injured, describe the nature of the injury:

- [ ] No
- [ ] Yes (If yes, print name and title/position) →

First Aid Provided - include date, time, type of first aid and who administered.

### COMPLETE THIS BLOCK ONLY IN THE EVENT OF AN EXPOSURE INCIDENT.

**Route(s) of exposure**

- [ ] Blood
- [ ] Needlestick
- [ ] Other

**Source individual information:** Identification known?

- [ ] No
- [ ] Yes; Hospital no. (If yes, print name and title/position)

- [ ] No
- [ ] Yes; Known to be infected with HBV or HIV

- [ ] Unwilling
- [ ] Known to be infected with HBV or HIV

- [ ] Other

If no, check one:

- [ ] Unwilling
- [ ] Known to be infected with HBV or HIV

- [ ] Other

If yes, results:

- [ ] Negative
- [ ] Positive

- [ ] Other

Identify source individual hospital no. ONLY if permitted by state law.

### HEALTHCARE PROFESSIONAL'S REPORT

- Healthcare provider–Please complete and return one copy of this written report to the facility indicated above within 15 days of completion of evaluation.

**Hepatitis B vaccination**

- [ ] IS
- [ ] IS NOT

**Route (check one)**

- [ ] Intramuscular
- [ ] Intradermal
- [ ] Other

**HBV vaccination was administered**

- [ ] Yes
- [ ] No

Findings and recommended follow-up:

- [ ] Employee/Patient has been informed of diagnosis and (if applicable) recommended follow-up treatment.

**Physician signature**

- [ ] Date