McLaren Business Products

McLaren Print System Order

Order No: 8969 Reprint Previous Order No: 5684
Order Date: 2015-02-11
User: Danielle Sowers
Phone: 586-791-7630

Ship Location: McLaren Family Medicine/Danielle Sowers
35103 Silvano Drive
Clinton Township, MI 48035
Forms
Quantity: 100
Paragon Dept No: 71000
Dept Name: Mclaren Family Medicine/Silvan
Company Number: 810

Order Total Price: 0.00

Item Number: PS-1772
Item Description: Employee Occupational Incident Report
Revision Date: 1/2014
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren HEALTH CARE

EMPLOYEE OCCUPATIONAL INCIDENT REPORT

☐ BAY ☐ LANSING ☐ MHC ☐ FLINT ☐ OAKLAND ☐ LONC ☐ KARMANOS ☐ MMG: _____
☐ BSC ☐ LAPEER ☐ MHP ☐ MNM ☐ CENTRAL ☐ MACOMB ☐ VC ☐ BPT ☐ MHG: _____

OSHA#: _____

EMPLOYEE SECTION

EMPLOYEE NUMBER | DEPT/DIVISION | INJURY DATE | INJURY TIME | DATE REPORTED TO SUPERVISOR/MANAGER

NAME | JOB TITLE | SHIFT START STOP

STREET ADDRESS | CITY/STATE/ZIP | ☐ FULL TIME ☐ PART TIME ☐ OTHER _____ | HIRE DATE

HOME PHONE ( ) | WORK PHONE ( ) | BIRTH DATE | SEX ☐ MALE ☐ FEMALE | SOCIAL SECURITY NUMBER

PART OF BODY INJURED (INCLUDE ALL BODY PARTS INJURED)

☐ ABDOMEN
☐ ANKLE ☐ L ☐ R
☐ ARM ☐ L ☐ R
☐ BACK
☐ BUTTOCKS
☐ CHEST
☐ EAR ☐ L ☐ R
☐ ELBOW ☐ L ☐ R
☐ ENTIRE BODY
☐ EYE ☐ L ☐ R
☐ FOOT/TOES ☐ L ☐ R SPECIFY _____
☐ GROIN/GENITALIA
☐ HAND/FINGER ☐ L ☐ R SPECIFY _____
☐ HEAD/FACE
☐ HEMATOCARDIOVASCULAR
☐ HIP/PELVIS
☐ LEG ☐ L ☐ R
☐ KNEE ☐ L ☐ R
☐ LUNG/PULMONARY
☐ MENTAL/EMOTIONAL
☐ MOUTH/DENTAL
☐ NECK
☐ NERVOUS SYSTEM
☐ NOSE
☐ SHOULDER ☐ L ☐ R
☐ UNKNOWN
☐ WRIST ☐ L ☐ R
☐ OTHER (SPECIFY) _____

DESCRIBE INCIDENT SPECIFICALLY

WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?

WHAT HAPPENED?

WHAT WAS THE INJURY OR ILLNESS?

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORDS TO AUTHORIZED CORPORATE PHYSICIAN, CORPORATE HEALTH OFFICE, INSURANCE CARRIER OR AGENTS FOR CASE MANAGEMENT, WORKERS' COMPENSATION, OR INSURANCE PURPOSES. ☐ TREATMENT REFUSED

SIGNATURE OF EMPLOYEE X | DATE

Incident report completed by: _____ Date: _____
Title: _____ Phone: ( ) _____