

## McLaren Print System Order

Order No: 9127 Reprint Previous Order No: 5684  
 Order Date: 2015-02-17  
 User: lynn thomas  
 Phone: 810-487-3500

Ship Location: Flushing Community Medical Center  
 2487 N Elms Rd  
 Flushing, MI 48433

### Forms

Quantity: 100  
 Paragon Dept No: 63600  
 Dept Name: Flushing  
 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									
OSHA#:		<input type="checkbox"/> BAY	<input type="checkbox"/> LANSING	<input type="checkbox"/> MHC	<input type="checkbox"/> FLINT	<input type="checkbox"/> OAKLAND	<input type="checkbox"/> LONG	<input type="checkbox"/> KARMANOS	<input type="checkbox"/> MMG		
		<input type="checkbox"/> BSC	<input type="checkbox"/> LAPEER	<input type="checkbox"/> MHP	<input type="checkbox"/> MINN	<input type="checkbox"/> CENTRAL	<input type="checkbox"/> MACOMB	<input type="checkbox"/> VC	<input type="checkbox"/> EPT	<input type="checkbox"/> MHG	
EMPLOYEE SECTION											
EMPLOYEE NUMBER	DEPARTMENT	INJURY DATE	INJURY TIME	DATE REPORTED TO SUPERVISOR/NAME							
NAME	JOB TITLE		SHIFT		START		STOP				
STREET ADDRESS	CITY/STATE/ZIP		<input type="checkbox"/> FULL TIME	<input type="checkbox"/> PART TIME	HIRE DATE						
PHONE NUMBER	WORK PHONE	BIRTH DATE	SEX	SOCIAL SECURITY NUMBER							
E	S		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE							
PART OF BODY INJURED (INCLUDE ALL BODY PARTS INJURED)											
<input type="checkbox"/> ABDOMEN	<input type="checkbox"/> ANGLE	<input type="checkbox"/> ARM	<input type="checkbox"/> BACK	<input type="checkbox"/> BUTTOCK	<input type="checkbox"/> CHEST	<input type="checkbox"/> EAR	<input type="checkbox"/> EYE	<input type="checkbox"/> FACE	<input type="checkbox"/> HAND/FOOT	<input type="checkbox"/> HEAD/NECK	<input type="checkbox"/> HEEL
<input type="checkbox"/> INDEX	<input type="checkbox"/> MIDDLE	<input type="checkbox"/> RING	<input type="checkbox"/> SMALL	<input type="checkbox"/> THUMB	<input type="checkbox"/> TOE	<input type="checkbox"/> WRIST	<input type="checkbox"/> ELBOW	<input type="checkbox"/> KNEE	<input type="checkbox"/> SHOULDER	<input type="checkbox"/> HIP	<input type="checkbox"/> LEG
<input type="checkbox"/> FOOT/TOE	<input type="checkbox"/> GROIN/GENITALIA	<input type="checkbox"/> NECK	<input type="checkbox"/> SPINE	<input type="checkbox"/> HEADFACE	<input type="checkbox"/> HEART/CARDIOVASCULAR	<input type="checkbox"/> LUNG	<input type="checkbox"/> LIVER	<input type="checkbox"/> PANCREAS	<input type="checkbox"/> STOMACH	<input type="checkbox"/> SMALL INTESTINE	<input type="checkbox"/> LARGE INTESTINE
<input type="checkbox"/> SKIN	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> 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 OCE MANAGEMENT, WORKERS' COMPENSATION, OR INSURANCE PURPOSES. <input type="checkbox"/> TREATMENT PURPOSE											
SIGNATURE OF EMPLOYEE <input checked="" type="checkbox"/>										DATE	
Incident report completed by:										Date	
Title										Phone ( )	