Alarys HOME CARE

Incident/Accident Report

Client Company: ___________________________ Employee: ___________________________ Department: ____________________

Date and Time Reported: ____________________ Date of Incident: ______________ Time of Incident: _____________ a.m./p.m.

1. **Type of Incident:** ☐ **Slip/Fall** ☐ **Cut/Puncture Wound** ☐ **Chemical Spill** ☐ **Occupational Exposure** ☐ **Vehicle** ☐ **Other**

Was medical care required ○ **Yes** ○ **No**

Incident reported by: ____ Date: ___________________________ The Employee's description of the Incident /Accident is: **(Must be hand-written by injured employee - use separate sheet if necessary-be specific as to the body part that is injured)**

2. **If VEHICLE accident: Complete this form, Vehicle Accident Report Form and attach a copy of the police report, if available.**

3. If **OCCUPATIONAL EXPOSURE**, complete the following: Type of Device(s) ____________ Brand ________________________
Size of device ___________ Procedure being performed: ___________________________________ What step in procedure did injury occur? ____ Testing done on Source Patient ○ Yes ○ No
Results of Source Patient's Tests: Known to be positive for: ☐ HBV ☐ HCV ☐ HIV ☐ None ☐ Waiting on Results
Employee was counseled for Post-Exposure Prophylaxis (PEP) & given written information accordingly: ○ Yes ○ No
PLEASE CHECK one of the following:
_____ Employee requests post-exposure medical evaluation
_____ Employee has refused post-exposure medical evaluation (must sign Informed Refusal of Post Exposure Medical Evaluation)
_____ Employee does not want testing at this time, but requests to draw and store blood for possible testing within the next 90 days.

Detailed description of any first aid given at time of occurrence: ____
____
____

I AGREE TO THE INFORMATION AS DESCRIBED ABVOVE: ○ YES ○ NO
If no, please comment: ____
____
____

Employee Signature: ____ Date ______________
Supervisor Signature: ____ Date ______________

EMPLOYEE COUNSELING

Date counseled: ___________________ Counseled by: ___________________________________
Recommendations (possible measures to be taken to avoid similar incident or accident) ____
____

___________________________________ ______________
Employee's Signature Date

___________________________________ ______________
Manager's Signature Date

WITNESS(ES) OF THE INCIDENT/ACCIDENT
1. Name: ____________________________ Work #: ___________________ Mobile#: _______________________
2. Name: ____________________________ Work #: ___________________ Mobile#: _______________________

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