Lifetime Assistance Inc.

Employee Report of Injury
(Complete within 24 hours of injury date)

Injured Employee Name	Employee Address	Home/Cell Phone	Work Phone
Date of Birth / Sex ☐ M ☐ F	Location Employed		
Job Title	Program	Who is Immediate Supervisor	Injury Date & Time
Did Injury Occur on Company Premises? ☐ Y ☐ N	Accident Location Address	Normal Work Location? ☐ Yes ☐ No If no, what is the location address:	
Days Normally Worked ; ☐Mon ☐Thur ☐Sat ☐Tues ☐Fri ☐Sun ☐Wed ___Total Hrs. Scheduled		Paid for Day of Injury? ☐ Yes ☐ No	
Doctor/Hospital (Name, Address)? Date first treated		Consumer Involved in Accident: ☐Yes ☐No If yes, consumer name:	
To be completed by HR	Date Lost Time Began	Expected Date of Return	Returned to Work Date

Injury/Illness
- ☐ Abrasion
- ☐ Amputation
- ☐ Animal Bite
- ☐ Bruise/Contusion
- ☐ Burn
- ☐ Dislocation
- ☐ Foreign Body
- ☐ Fracture
- ☐ Human Bite
- ☐ Infection
- ☐ Inflammation
- ☐ Laceration
- ☐ Muscle Tear
- ☐ Puncture
- ☐ Repetitive Motion
- ☐ Skin Disorder
- ☐ Shock
- ☐ Stress Related
- ☐ Sprain
- ☐ Strain
- ☐ Other (describe in Sec A)

Body Part
- ☐ Abdomen
- ☐ Ankle (Lt/Rt)
- ☐ Arm (Lt/Rt)
- ☐ Back
- ☐ Buttock
- ☐ Chest
- ☐ Elbow (Lt/Rt)
- ☐ Eye (Lt/Rt)
- ☐ Neck
- ☐ Shoulder (Lt/Rt)
- ☐ Face
- ☐ Finger
- ☐ Foot (Lt/Rt)
- ☐ Groin
- ☐ Hand (Lt/Rt)
- ☐ Head
- ☐ Ear (Lt/Rt)
- ☐ Hip (Lt/Rt)
- ☐ Knee (Lt/Rt)
- ☐ Leg (Lt/Rt)
- ☐ Wrist (Lt/Rt)
- ☐ Toe
- ☐ Teeth
- ☐ Other (describe in Sec A)

Injury Source
- ☐ Bodily Motion
- ☐ Chemical (describe in Sec A)
- ☐ Electrical
- ☐ Fire/Explosion
- ☐ Stationary Object
- ☐ Machinery
- ☐ Material Handled
- ☐ Motor Vehicle
- ☐ Consumer Interaction
- ☐ Stairs/Ladder
- ☐ Tool Related
- ☐ Walking Surface
- ☐ Work Surface
- ☐ Sports Related
- ☐ Lifting Object
- ☐ Lifting Consumer
- ☐ Other (describe in Sec A)

Accident Type
- ☐ Absorption, inhalation, ingestion of toxins
- ☐ Allergic Reaction
- ☐ Caught in/under/between
- ☐ Contact w/electrical
- ☐ Puncture
- ☐ Explosion
- ☐ Fall from elevation
- ☐ Fall on same level
- ☐ Motor Vehicle
- ☐ Slip on Ice
- ☐ SCIP Intervention
- ☐ Struck against
- ☐ Struck by
- ☐ Other (describe in Sec A

A. Please Describe what happened, medical treatment given. What were you doing? Where did the accident happen? Describe how the accident occurred (include names and comments of any witnesses)

_____
_____
_____
_____

B. If mechanical apparatus is involved in accident please indicate the type of apparatus.

_____
_____
_____
_____

C. What could have been done differently?

_____
_____
_____
_____

D. Witness Name and Phone Number (if none then N/A)

_____
_____
_____
_____

E. Employee Comments: your comments are important to us and may help prevent future accidents and injuries.

_____
_____
_____

Employee Signature_____Date_____

Note: Employee is to send / give this report to their immediate supervisor within 24 hours for date of injury.

Supervisor Report of Injury
(Complete within 24 hours of injury date)

Employee's Name: _____

A. Cause of Incident (check all that apply)

- ☐ Distraction/inattention
- ☐ Inappropriate footwear
- ☐ Additional Training
- ☐ SCIP related
- ☐ Failure to follow care plan
- ☐ Inadequate Work Practice
- ☐ Operating at unsafe speeds
- ☐ Failure to secure (wheel chair)
- ☐ Failure to use proper protective equipment
- ☐ Inadequate housekeeping
- ☐ Failure to wear proper attire
- ☐ Incorrect transfer of individual*
- ☐ Horseplay
- ☐ Using defective equipment/tools
- ☐ Improper use of equipment/tools
- ☐ Inadequate maintenance of equipment
- ☐ Incorrect lifting/carrying*
- ☐ Other (describe)

*(fill out Work Positioning, Section B below)

B. Work Positioning (if applicable)

- ☐ Before SCIP ☐ During SCIP ☐ After SCIP ☐ Behavior support Plan
- ☐ Consumer Transfer – Consumer dropped self
- ☐ Consumer Transfer – improper gait belt use
- ☐ Consumer Transfer – Improper fall assistance

C. If SCIP- R was involved, what technique was used? Done properly?

_____
_____
_____
_____

D. Action(s) required to prevent recurrence

- ☐ Individual Plan of Protection (IPOP)
- ☐ Improve housekeeping/maintenance
- ☐ Improve job orientation/training
- ☐ Root Cause Analysis
- ☐ Other (specify)
- ☐ Supervisor Follow up needed
- ☐ Initiate/revise/enforce rules
- ☐ Provide/monitor protective equipment
- ☐ Provide special communications
- ☐ Revise equipment or layout (Hoyer)
- ☐ Notify Behavior Specialist

_____
_____
_____

E. Describe Specific Corrective Action and Target Completion Date:

_____
_____
_____

Supervisor Signature _____Date_____

To Be Completed by HR	
Prepared by:	
Title	Date

11/2010