

City of Winona EMPLOYEE INCIDENT REPORT

This form should be used to report any and all work related injuries and incidents occurring while working for the City of Winona. The reverse side of this form must be completed in addition when an exposure to potentially infectious material occurs. Employee and supervisor signatures are required. Submit all completed forms to the Occupational Safety and Health Coordinator within 48 hours of the incident. Each incident must be investigated by a supervisor and all sections of this form completed.

Date of incident: _____ Time of Incident: _____ Date Form Completed: _____
Employee Name _____ Date of Hire _____
Address: _____
Street City State Zip Code
Birth Date: _____ Phone: _____ Social Security Number: _____ - _____ - _____
Department: _____ Title: _____ Full Time: Part Time:
Name of Supervisor Notified: _____ Date Notified: _____
Location of Incident (Work Area): _____
Name of Witness/es: _____

INCIDENT: Describe in detail how incident occurred, what you were doing at the time, who/what equipment was involved and what body part was affected (be specific). _____

(Use additional sheet of paper if more room is needed for details)

Please answer the following:

1. Were you instructed in a safe and efficient method to do this job? yes no
 2. Did you follow the procedure given? yes no
 3. Was necessary protective equipment worn? yes no
 4. Did poor housekeeping contribute to this incident? yes no
 5. Did horseplay cause this incident? yes no
 6. Was the equipment being used in good repair? yes no
 7. Did you report this incident to your supervisor immediately? yes no
 8. Did an unsafe act contribute to this incident? yes no
- If yes, what was the unsafe act? _____

I AUTHORIZE RELEASE OF MEDICAL INFORMATION PERTAINING TO THIS INJURY
EMPLOYEE SIGNATURE: _____

SUPERVISORS COMMENTS AND INVESTIGATION

1. Do you feel this incident was related to a work activity? yes no
 2. Did an unsafe act contribute to this incident? yes no
If yes what do you feel that was? _____
 3. Was unsafe equipment, building, or environment a contributing factor? yes no
If yes what was it? _____
- Additional comments: _____

What action has been taken to correct or prevent this type of incident from happening again?

Was first aid or medical attention given? yes no Did incident cause loss of time? yes no
Name of treating Physician _____ Initial visit date: _____

IMMEDIATE SUPERVISOR SIGNATURE: _____ Date: _____

Please complete all information on the other side of this report form before completing this side and complete this side only if incident involving an exposure to blood or other potentially infectious material has occurred.

City of Winona Communicable Disease Exposure Report Form

Exposed Employees Name: _____

Date/Time of Exposure: _____ Last Bloodborne Pathogens Training: _____

Name of Person who you were exposed to (source): _____
(If known)

Location of exposure: _____ Address of source: _____
(or field incident number) (If Known)

Medical facility transferred to: _____

Type of Incident: Medical M.V. Accident Trauma Criminal investigation/arrest
 Maintenance Other _____

How did exposure occur? _____

What were you exposed to? Blood saliva Feces urine Vomit Other _____

What part(s) of your body was exposed to contaminate? Be specific _____
Was skin intact?(rashes, cuts, etc.) _____

What protective equipment was being used? _____

(List brand name of equipment if known)

How could exposure have been prevented? _____

Medical attention provided by: _____

Source Hepatitis B, C or HIV status known? yes no

Testing of source patient's blood has been requested completed

Has exposed employee been vaccinated for Hepatitis B? yes no

Does this exposure require follow-up testing or treatment? yes no

Draw blood on exposed for testing:

- a) Hepatitis B profile if not vaccinated c) Hepatitis C
 b) Anti HBs titer if vaccinated d) HIV

Health Care Providers Signature: _____ Date: _____

I, the exposed, give permission for my blood to be drawn and be tested for the above checked item/s

now or held up to 90 days for future testing. I authorize release of my test results for follow-up by the Occupational Health and Safety Coordinator or Dr. _____.

Signature: _____ Date: _____

I understand that blood tests are confidential and will not release any information obtained during this exposure follow-up on the source patient without their consent

Signature: _____ Date: _____