**Per NMCAA** [**Personnel Policies**](https://www.nmcaahr.com/policies.html)**: *ALL EMPLOYEES MUST ADHERE TO THE POLICY REGARDING THE REPORTING OF ACCIDENTS. FAILURE TO DO SO CAN JEOPARDIZE ENTITLEMENT TO WORKERS’ COMPENSATION BENEFITS, IF ANY****.*

Completed report must be returned within **24 hours** of the incident.

|  |
| --- |
| PERSONAL INFORMATION |
| **NAME:**   | **DATE OF BIRTH:**  | **HOME PHONE:**  | **WORK PHONE:**  |
| **MAILING ADDRESS**:  | **CITY:**  | **STATE:**   | **ZIP CODE:**  |
| **DEPARTMENT:**   | **JOB TITLE:**   | **SUPERVISOR:**   |

|  |
| --- |
| INCIDENT INFORMATION |
| **DATE OF INCIDENT:**  | **TIME OF INCIDENT:**  | [ ]  **AM** [ ]  **PM** | **FINISHED SHIFT?** [ ]  **YES** [ ]  **NO** [ ]  **N/A** |
| **LOCATION OF INCIDENT (address/city):**  | **NMCAA PROPERTY?** [ ]  **YES**  [ ]  **NO** |
| **HOW DID THE INCIDENT HAPPEN? DESCRIBE THE CONDITIONS/CIRCUMSTANCES WHICH LED TO THE INCIDENT OCCURING. BE SPECIFIC!**  |
| **LIST THE BODY PART(S) INJURED AND TYPE OF INJURY (Example: Skin cut on right index finger):**  |
| **HOW DO YOU THINK THIS TYPE OF INCIDENT CAN BE PREVENTED? WHAT ACTION WILL BE TAKEN TO PREVENT RECURRENCE?**  |
| **INCIDENT REPORTED?** [ ]  **YES**  [ ]  **NO** | **IF YES, TO WHOM DID YOU REPORT IT?**  | **DATE REPORTED:**  |
| **WITNESSES?** [ ]  **YES** [ ]  **NO** | **IF YES, WITNESS #1 (NAME/PHONE):**  | **WITNESS #2 (NAME/PHONE):**  |

|  |
| --- |
| TREATMENT INFORMATION |
| **DID YOU RECEIVE TREATMENT?** | [ ]  NONE REQUIRED \*\*\* [ ]  REFUSED \*\*\*[ ]  TREATMENT PROVIDED [ ]  WILL BE PROVIDED/SOUGHT  | **WHO PROVIDED TREATMENT?** |  [ ]  SELF [ ]  URGENT CARE [ ]  N/A [ ]  PRIMARY CARE DR. [ ]  EMERGENCY ROOM |
| **\*\*\* *PLEASE SIGN INDICATING THAT NO MEDICAL TREATMENT IS NEEDED*** | **EMPLOYEE SIGNATURE:**  | **DATE SIGNED:**  |
| **TREATMENT PROVIDER DETAILS** | **PROVIDER NAME:**  | **ADDRESS:**  | **PHONE:**  |
| **DESCRIBE TREATMENT PROVIDED:** ***\*\*\* Clinical/hospital paperwork MUST be submitted with this completed form.*** | **RELEASED FROM CARE?**[ ]  **YES: RELEASED** [ ]  **NO: FOLLOW UP NEEDED** |
| **ARE THERE RESTRICTIONS?** [ ]  **YES (provide documents)**[ ]  **NO** |

***My signature below indicates that the information contained in this report to be true and correct.***

|  |  |  |  |
| --- | --- | --- | --- |
| **EMPLOYEE SIGNATURE:**   | **DATE:**  | **SUPERVISOR SIGNATURE:**   | **DATE:**  |

|  |
| --- |
|  **PLEASE EMAIL/FAX THIS COMPLETED FORM AND ANY NECESSARY DOCUMENTATION WITHIN 24 HOURS** **OF THE INCIDENT TO THE FOLLOWING:****Julie McNally:** **jmcnally@nmcaa.net****FAX: 231.922.0595** |

Distribution: **Original** to Julie McNally **COPY**: Employee file on site; Supervisor