**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.

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

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| 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):** | | | |

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| 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:** |

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

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