Mount Sinai

☐ Beth Israel Medical Center ☐ Beth Israel Brooklyn

☐ St. Luke's Hospital ☐ Roosevelt Hospital

EMPLOYEE INCIDENT REPORT – PART A
EMPLOYEE AND EMPLOYER STATEMENT

Section I	*TO BE COMPLETED BY EMPLOYEE AND/OR SUPERVISOR*		
Date of Incident	**Time of Incident** _____ ☐ AM ☐ PM	**Time work shift began** _____ ☐ AM ☐ PM	
Employee's Name	**Home Address** (include City, State and Zip Code)		
Home Telephone	**(Payroll) Employee Number (6 digits)**	**Date of Birth**	**Gender** ☐ M ☐ F
Social Security Number	**Employee's Job Title**	**Employee's Department**	**Date of Hire**
Job Experience (Years and Months in Profession)	**Location where incident occurred** (building, department, floor, room)		
Nature of Injury or Illness (e.g., needle stick to finger, strain to lower back, chemical splash to eye). Specify any object/substance that caused the injury/illness:			
If incident involves exposure to patient body fluid(s), provide Source Patient Medical Record #:			
Was this a "Sharps" injury? ☐ Yes ☐ No	**If yes, did object have a safety device?** ☐ Yes ☐ No	**Specify type and brand of device:**	**If a "Sharps" injury, was the needle or object contaminated with blood or other potentially infectious material (OPIM)?** ☐ Yes ☐ No
What was employee doing when he/she was injured or became ill? (e.g., suturing wound, lifting patient, carrying equipment, etc.)			
Provide a complete description of the incident (what occurred, how it occurred, why it occurred)			
Name of Witness 1 and Telephone Number		**Name of Witness 2 and Telephone Number**	
Name of Witness 3 and Telephone Number		**Name of Witness 4 and Telephone Number**	

EMPLOYEE INCIDENT REPORT – PART A (continued)			
Section II	***TO BE COMPLETED BY SUPERVISOR AND DEPARTMENT HEAD***		
EMPLOYEE'S NAME:		**DATE OF INCIDENT:**	
Date incident was reported to you	**Time Reported:** _____ ☐ AM ☐ PM	**Did employee return to work** (not counting day of incident)? ☐ Yes ☐ No	
What is the last date the employee worked?	**What is the first date employee was absent from work (based on usual work schedule)?**	**What date did or will employee return to work?**	
Employee Treated In: ☐ E.R. ☐ Employee Health Services ☐ Private MD ☐ Other _____ ☐ Refused Treatment			
Body Part Injured (be specific – e.g., index finger on left hand, right hip, calf on right leg)			
Provide the results of your investigation including photographs and diagrams:			
What Corrective Actions have been taken or need to be taken to prevent additional occurrences?			
Section III	***REQUIRED SIGNATURES***		
Name of Employee	**Signature**	**Date**	**Work Telephone**
Employee Email Address:			
Name of Supervisor	**Signature**	**Date**	**Work Telephone**
Supervisor Email Address:			
Name of Department Head	**Signature**	**Date**	**Work Telephone**
Department Head Email Address:			

Employee's supervisor or other designated departmental staff:

1. should print **PART A** of this report and obtain required signatures
2. Obtain completed **PART B** from the employee
3. scan and send **both Part A and Part B** (the physician's statement) via email* to the following departments:

Department	**Site**	**Email Address**
Human Resources Benefits Division	Corp	HRWC@chpnet.org
Employee Health Services (EHS)	BI	BI_EHS@chpnet.org
	SLR	SLREHS@chpnet.org
Environmental Safety Department	BI	BISafety@chpnet.org
	SLR	SLR_Safety@chpnet.org

The supervisor should also give or send a copy of the completed report to the injured/ill employee.

* You may also fax the completed report. Please refer to the *Instructions* on page 4.

Continuum Health Partners
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NY Eye and Ear Infirmary

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EMPLOYEE INCIDENT REPORT – PART B

ATTENDING PHYSICIAN'S STATEMENT

Employee: Print this page (Part B) and take it with you to Employee Health Services or the Emergency Department for completion.

TO BE COMPLETED BY EMPLOYEE			
Employee's Name	**Date of Birth**	**Date of Incident**	**Gender** ☐ M ☐ F

TO BE COMPLETED BY TREATING PHYSICIAN		
Employee Treated In: ☐ E.R. ☐ Employee Health Services ☐ Private MD ☐ Other _____ ☐ Refused Treatment		
Date of Visit:	**Patient (Employee) Medical Record (MR) #**	
Can employee return to work the same date the incident occurred? ☐ Yes ☐ No		
If no, when can employee return to work? ☐ 24 hours ☐ 48 hours ☐ 72 hours ☐ Longer than 72 hours		
Was employee admitted to hospital overnight? ☐ Yes ☐ No	**Was employee prescribed medication for this injury or illness?** ☐ Yes ☐ No	
Describe the treatment received (e.g., ice pack, stitches, hard cast, antibiotics, no treatment necessary)		
Name of Physician (print)		
Office Address		
Telephone Number	**Signature**	**Date**

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EMPLOYEE INCIDENT REPORT – PART C

(FOR ENVIRONMENTAL HEALTH & SAFETY USE ONLY)

EMPLOYEE'S NAME:	**DATE OF INCIDENT:**
Is incident OSHA recordable? ☐ Yes ☐ No	**If OSHA recordable, what is the OSHA 300 log case number?**
Provide the results of EH&S investigation, if applicable:	
Name of Investigator	**Date of investigation**

INSTRUCTIONS

When an employee is injured on hospital property or becomes ill in connection with his or her job, the employee and/or supervisor must immediately report the incident. The *Employee Incident Report* form should be used to report such injuries or whenever an employee contracts an illness or other condition as a result of his or her employment.

PROCEDURES FOR REPORTING AN INCIDENT

- The employee and supervisor must complete this form immediately after the accident or condition occurs.
- A Beth Israel employee should go to Employee Health Services (EHS) with the *Employee Incident Report - Part B*. If EHS is closed, the employee should go to the Emergency Room with the *Employee Incident Report - Part B*.
- A St. Luke's and Roosevelt Hospital employee should to the Emergency Room with the *Employee Incident Report - Part B*.
- The Department Head is responsible for the completeness, clarity, and legibility of the report and the delivery of the completed *Employee Incident Report* to the departments noted on the form.

EMPLOYEE INCIDENT REPORT – PART A

Section 1 – To be completed by the employee or supervisor (if employee is unable to complete this section)

The description of the accident should include **how** and **why** the incident occurred and the specific body part that was injured. Be very specific, indicate left or right where appropriate as well as which digit of hands or feet are involved. For example, "third finger of left hand."

Section II – To be completed by the supervisor and department head

The Supervisor in charge when the incident or illness occurred should:

- complete this section
- review Section I to be sure it is complete and attain missing information from the employee if needed
- print the completed *Employee Incident Report - Part A*, sign and date it and have the department head sign as well
- check the employee's file and report to HR Benefits, EHS and Safety any prior injuries or illnesses related to this incident.

The Department Head:

- should co-sign *Employee Incident Report - Part A*
- is responsible for taking actions noted in this section to avoid similar incidents

EMPLOYEE INCIDENT REPORT – PART B

The employee should complete the top of *Employee Incident Report - Part B* and bring it to the treating physician so that he/she may complete the physician section.

The department supervisor must distribute completed incident reports (Parts A and B) to:

1. *Human Resources Department*, Benefits Division, 555 West 57th Street, 19th Floor, New York, NY 10019; Email: HRWC@chpnet.org; Fax Number: 212 523-5610.

2. *Employee Health Services (EHS)*:
    a. Beth Israel Petrie and Beth Israel Brooklyn, email to BI_EHS@chpnet.org
    b. Beth Israel Petrie, fax to 212-844-1762
    c. Beth Israel Brooklyn, fax to 718-951-3085
    d. St. Luke's and Roosevelt, email to SLREHS@chpnet.org or fax to 212-523-2346.

3. *Environmental Health & Safety Department*: For Beth Israel, email to BISafety@chpnet.org or fax to 212-420-3008; for St. Luke's and Roosevelt, email to SLR_Safety@chpnet.org or fax to 212-523-7241.

4. *The injured/ill Employee* by hand or mail to employee's home.