St. Clair County Community Mental Health

# Employee Accident Report

**(COPY FOR SUPERVISOR AND FORWARD BY FAX THIS PAGE TO ADMINISTRATION IMMEDIATELY.)**

**Complete for all work-related injuries within 24 hours.**

Injured Employee: ______________________________________________
(Last Name) (First Name) (Initial)

Home Address: ______________________________________________
(Street) (City/State) (Zip)

Division/Program: ______________________ Title: ______________________

Date of Injury: __________________ Time of Injury: __________ a.m. __________ p.m.

Location of Occurrence: ______________________________________________

☐ Medical Emergency *(Requires Medical Care)* ☐ Non-Life Threatening Injury *(Requires Medical Care)* ☐ Minor Injury

**This Section to be completed by Employee (FORWARD TO ADMIN IMMEDIATELY)**

Injury Sustained to (arm, leg, etc.):
State specific nature of injury (burns, strain, etc.):

Was skin broken or blood involved: ☐ NO ☐ YES, complete the Hepatitis B Exposure Report, attached
Describe in detail the events, which led up to the accident:

Consumer Case Number (if involved):
Were there any unusual circumstances or perceived unsafe conditions:

First names of witnesses to the incident:

What recommendations would you make so that this would not happen again?

☐ I will immediately (the same day) seek treatment at IHS/ER at St. Clair County Community Mental Health's cost.

| Employee Signature | Date | Time |
|---|---|---|

☐ I will immediately (the same day*)* seek treatment with my own health care professional and St. Clair County Community Mental Health may or may not pay based upon individual circumstances and reasonableness.

| Employee Signature | Date | Time |
|---|---|---|

☐ I will not seek immediate treatment and release St. Clair County Community Mental Health for all liability related to this incident.

| Employee Signature | Date | Time |
|---|---|---|

St. Clair County Community Mental Health

# Employee Accident Report

**This Section to be completed by Supervisor after Investigation**
**(This page may be sent separately.)**

Injured Employee:______________________________________________________________________
(Last Name) (First Name) (Initial)

The Employee: ☐ Sought IHS/ER Treatment ☐ Sought his/her own Treatment ☐ Did not seek Treatment

Employee has completed the Hepatitis B vaccine series: ☐ Yes ☐ No

Employee went:
- ☐ To Work (only for minor injuries)
- ☐ Home (with approval)
- ☐ IHS or own doctor
- ☐ Emergency Room / Hospital

Other Staff:
- ☐ Administered First Aid
- ☐ Did Not Administer First Aid

Do you concur with the employee's report: ☐ Yes ☐ No If no, explain:

What recommendations would you make so that this would not happen again?

______________________________________ ______________________
Supervisor Signature Date

Review by Division Director (comments):

______________________________________ ______________________
Supervisor Signature Date

## Administrative Review

Review by Safety Designee (comments):

______________________________________ ______________________
Supervisor Signature Date

**Accident #:**________________________

HR Form: #06-0802
Reviewed Date: 1/1/2024
Policy Ref: #09-002-0020