

THE JOHNS HOPKINS INSTITUTIONS EMPLOYEE REPORT OF INCIDENT

INSTRUCTIONS

SERIOUS INJURY/ILLNESS: If an employee is seriously injured or becomes acutely ill on the job and needs immediate medical attention, call 5-4444. Examples of serious medical conditions include loss of consciousness, life threatening injury, seizing, and/or change in mental status. In such cases the employee should be accompanied by a supervisor or coworker. If there is a question of severity, contact the Occupational Injury Clinic (5-6433) for assistance in determining the appropriate care facility.

Employees:

1. Report any work-related injury or illness, no matter how minor, to your supervisor immediately.
2. Obtain a completed Employee Report of Incident from your supervisor and proceed to the Occupational injury clinic (Blaylock 139). When the clinic is closed, dial 5-6433 and listen for further instructions on the recording.
3. For EYE INJURIES report directly to the Emergency Room of the Wilmer Eye Institute (Wilmer 2).
4. For needlesticks or other BLOODBORNE PATHOGEN EXPOSURES dial 5-STIX (5-7849) **immediately** for further instructions.
5. If evaluated in the Adult or Wilmer Emergency Rooms or via a 5-STIX bloodborne pathogen exposure evaluation, contact the Occupational Injury Clinic on the next available business day for further disposition. The usual hours of operation are Monday – Friday 7:30 AM to 5:00 PM, with injury and exposure evaluations between 7:30 AM and 4:30 PM.

Supervisors:

1. Determine if the employee's illness or injury on the job needs immediate medical attention as outlined in the "serious injury/illness" block.
2. Complete an Employee Report of Incident. Retain a copy in the department. The original should accompany to the employee to the treatment location.
3. If unable to complete and incident report at the time of injury, a call to the Occupational Injury Clinic is required to properly identify the employee and department and provide a brief explanation of the incident. Forward the completed Employee Report of Incident form to the Occupational Injury Clinic *before the end of the shift*.
4. If the employee reports and injury, illness or hazards but refuses to proceed to the Occupational Injury Clinic, document the employee's claim on the Employee Report of Incident. Write "Employee refused treatment" on the form and send it to Blalock 139.
5. Discuss the injury/illness with the employee to prevent recurrence, understand factors involved, and arrange for engineering controls or other hazard abatement methods.

**THE JOHNS HOPKINS INSTITUTIONS
EMPLOYEE REPORT OF INCIDENT**

Name:	_____			
Social Security Number:	_____			
JHH History Number:	_____			
Employer (circle one):	JHH JHHS	SOM HWD	SOH MCS	BSI
Other (specify):	_____			

Part I. Employee Incident Information (to be completed and signed by the supervisor)

Occupation _____ Functional Unit/Department _____

Date of Incident _____ Time of Incident _____ AM/PM Date Reported _____

Time Work Day Began _____ AM/PM

Location of Incident _____ Building _____ Room _____

Description of Incident (Must include all equipment and materials employee was using at the time of incident as well as the specific activity employee was engaged in at the time of incident)

Was there a safety procedure or mechanism available? _____ Yes _____ No

Was it in use at the time of incident? _____ Yes _____ No

Is the activity part of the normal job duties? _____ Yes _____ No

List names of anyone present at time of incident: _____

Probable cause of incident (object or substance responsible for injury/illness) _____

If indicated, what was discussed with employee to prevent recurrence? _____

Date _____ Supervisor Name _____ Extension _____ Beeper _____

Employee's Signature

Supervisor's Signature

Note: Any additional comments you feel are pertinent to an investigation of this incident can be made on a supplemental sheet and attached.

Part II. Disposition - Occupational Injury Clinic Use Only

Inc # _____ Body Part _____ ICD9 DX Code _____

Disposition _____ Full Duty _____ Restricted Duty _____ Off Duty _____ Restrictions not Accommodated

_____ Referral (ER, WER, Otrho, Plastics, Etc) _____ RTC Scheduled _____ RTC PRN

Recordable* _____ Yes _____ No

Safety investigation requested _____ Yes _____ No If yes, comments: _____

Date _____ Healthcare Provider's Signature/Title _____

* As defined by OSHA

Distribution of Copies: Original - accompany the employee to Occupational Injury Clinic
Copy - retain in department

Revised: 11/01/05