# EMPLOYEE INCIDENT REPORT

## INSTRUCTIONS:

Employees should complete the sections: employee information; incident information; description of incident; medical treatment authorization and provide to their supervisor immediately. The employee’s supervisor will review the incident report and as deemed appropriate, authorize medical treatment by including their signature and escorting employee to medical treatment facility. The report must be provided to the medical treatment facility and returned to your supervisor immediately.

### EMPLOYEE INFORMATION:

| Name (Full): | ☐ Male ☐ Female Date of Birth: |
| UNCC ID #: | Date Hired or Years of Service: |
| Department: | Employment: ☐ Full Time ☐ Part Time ☐ Seasonal |
| Job Title: | Scheduled Work Days: Shift Hours: |
| Home/Cell #: | Supervisor: |
| Home Address: | City: State: Zip: |

### INCIDENT INFORMATION:

| Date of Incident: | Time: ☐ AM ☐ PM Time Reported to Work: ☐ AM ☐ PM |
| Date Reported to Supervisor: | Time: ☐ AM ☐ PM |
| Incident Location (Building/Room): | Incident Location if Outside/Grounds: |
| Type of Injury: | Body Part Injured: |

Prior to this incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? ☐ Yes ☐ No Date of Prior Injury: |
| Witness Name(s): | Phone #: |

### DESCRIPTION OF INCIDENT:


### EMPLOYEE CORRECTIVE ACTION SUGGESTION:


### MEDICAL TREATMENT AUTHORIZATION:

(Student Health Center is the first point of medical treatment for non-life threatening injuries.)

☐ No Medical Treatment / First Aid ☐ Student Health Center ☐ Urgent Care ☐ Hospital Emergency

☐ Employee Refused Treatment ☐ Other

I hereby certify that the information I have provided is true and accurate.

Employee Signature: Date: / / Office Phone: |

I hereby certify review of incident report and as deemed appropriate medical treatment authorization.

Supervisor Signature: Date: / / Office Phone: |

### MEDICAL TREATMENT FACILITY / INITIAL TREATING PHYSICIAN STATEMENT:

☐ May return to work on: ___________________________ without restrictions or limitations.

☐ May return to work on: ___________________________ with the following restrictions or limitations in effect until*:

- ☐ Light Work (Lifting less than 20lbs.) ☐ Medium Work (Lifting less than 50lbs.) ☐ Heavy Work (Lifting less than 100lbs.)
- ☐ Sedentary Work (Sitting, occasional walking, standing, lifting less than 10lbs.) ☐ Other

*Unless otherwise specified, restrictions are in effect until the end of the timeframe recommended by the physician to return if not improved.

☐ Should not return to work until evaluated by a consulting physician

Diagnosis/HX:

Comments: Follow-up Appointment Due: |

Referred to:

Physician’s Signature: Date: / /