

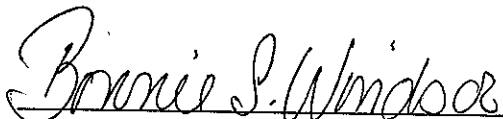
## REPORT OF INCIDENT

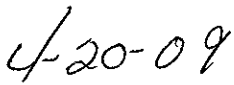
Intrastaff is committed to ensuring a safe working environment. Employees hold accountability for their actions and formally communicating those actions to management.

All incidences that take place during the course of a scheduled work day shall be reported to Intrastaff within twenty-four (24) hours. Any injuries must be reported immediately. An "Employee Report of Incident" form may be obtained from the departmental supervisor and must be completed and signed off by the departmental supervisor and the Intrastaff coordinator. Also, an Intrastaff Incident Report Form (Attachment A) should be filled out within that first twenty-four (24) hours. If treatment is needed, report to Occupational Injury Clinic (OIC) with the incident report form. If treatment is needed after regular business hours and OIC is closed, report to the JHH Emergency Room with the incident report form.

All requests for special accommodations will be reviewed by the current assignment supervisor and/or Intrastaff coordinator.

### APPROVAL:

  
\_\_\_\_\_  
Director, Intrastaff

  
\_\_\_\_\_  
Date

## 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 form from your supervisor and proceed to the Occupational Injury Clinic, Blalock 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 7:30AM - 5:00PM, with injury and exposure evaluation between 7:30AM and 4:30PM.

#### SUPERVISORS:

1. Determine if the employee's illness or injury on the job needs immediate medical attention as outlined in "serious injury/illness" block.
2. Complete an Employee Report of Incident. Retain the last copy; the first two copies should accompany the employee to the treatment location.
3. If unable to complete an 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 an 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 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**

<b>NAME:</b> <b>Social Security Number:</b> <b>JHH History Number:</b> <b>EMPLOYER (circle one):</b> JHH SOM SOH BSI JHHS HWD MSC <b>OTHER (specify):</b>
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**PART I. EMPLOYEE INCIDENT INFORMATION (TO BE COMPLETED AND SIGNED BY SUPERVISOR)**

OCCUPATION: \_\_\_\_\_ FUNCTIONAL UNIT/DEPARTMENT: \_\_\_\_\_

DATE OF INCIDENT: \_\_\_\_\_ TIME OF INCIDENT: \_\_\_\_\_ A.M./P.M. DATE REPORTED: \_\_\_\_\_

TIME WORKDAY BEGAN: \_\_\_\_\_ A.M./P.M.

LOCATION OF INCIDENT: \_\_\_\_\_ BUILDING: \_\_\_\_\_ ROOM: \_\_\_\_\_

DESCRIPTION OF INCIDENT (MUST INCLUDE ALL EQUIPMENT AND MATERIALS EMPLOYEE WAS USING AT TIME OF INCIDENT AS WELL AS THE SPECIFIC ACTIVITY EMPLOYEE WAS ENGAGED IN AT TIME OF INCIDENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WAS THERE A SAFETY PROCEDURE OR MECHANISM AVAILABLE?  YES  NO.

WAS IT IN USE AT TIME OF INCIDENT?  YES  NO.

IS THE ACTIVITY PART OF 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.**

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**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, ORTHO, PLASTICS, ETC)  RTC SCHEDULED  RTC PRN

RECORDABLE\*:

SAFETY INVESTIGATION REQUESTED:  YES  NO IF YES, COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

DATE: \_\_\_\_\_ HEALTH CARE PROVIDER SIGNATURE/TITLE: \_\_\_\_\_

\*as defined by OSHA

**DISTRIBUTION OF COPIES:**

*White and yellow--accompany employee to Occupational Injury Clinic, Blalock 139.  
Pink--retain in department*