

This report is to be completed when occupational illness or incident occurs. If an employee is injured or develops a job-related illness as a result of his/her employment at TWCC, s/he must complete and submit the "Incident Report". If the employee is unable to complete the form, the supervisor must complete on his/her behalf.

Please complete each section. If you have any questions, please ask the office administrator.

**THE WOMEN'S CARE CENTER**  
**INCIDENT REPORT FORM**

<b><u>EMPLOYEE INFORMATION:</u></b>					
<i>Employee Completes This Section</i>					
Campus Location:	Riverside		Employee's ID:		
Employee's Name (PRINT):			Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Home Address:			City, State:	Zip:	
Home Phone:			Work Phone:		
Department:			Title Code/Job Title:		
Work Hours:			Hours Worked per Week:		
Employment Type:	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Career	<input type="checkbox"/> Limited appointment	<input type="checkbox"/> Volunteer
Do you have other employment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, where:		
<b><u>INCIDENT INFORMATION</u></b>					
Date of Incident:			Time of Incident:	<input type="checkbox"/> a.m.	<input type="checkbox"/> p.m.
Location of Incident: (choose one)	10235 HICKORYWOOD HILL AVE		If "other", please specify:	Zip code:	
	508 EASTWAY DRIVE				
State all parts of body and type of injuries involved(e.g. bruised right elbow):					
Describe how incident occurred:					
Was incident reported?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "yes" to whom:		
Date reported:					
Were there witnesses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown		
Name of Witness #1 (First and Last):					
Witnesses #1 Phone:					
Name of Witness #2 (First and Last):					
Witnesses #2 Phone:					
Is this a new injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "no", please indicate the date of original injury:		
<b><u>INITIAL MEDICAL TREATMENT:</u></b>					
Was treatment received for this injury?					
<input type="checkbox"/> No medical treatment – reporting only					
<input type="checkbox"/> Declining treatment at this time					
<input type="checkbox"/> Treatment was/will be provided					
Treatment was provided by:	<input type="checkbox"/> Self	<input type="checkbox"/> Occupational Health	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Other (please specify below)	

If treatment was provided, name and location of medical provider:			
Name:		Phone:	
Address:			
<b>I, the injured employee, herein certify the information above is true and to best of my knowledge.</b>			
Date:		Signature of Employee:	

<b>SUPERVISOR COMPLETES THIS SECTION:</b>			
Supervisor Name :			
Work Phone:		Work e-mail address:	
Describe how the employee was injured?			
Did the employee loose time from work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date the employee returned to work:	If "yes", first day of lost time:		
Was there equipment involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "yes", what was the equipment?
What action will be taken to prevent recurrence?			
Other comments:			
Date:		Signature:	Title:

<b>MEDICAL PROVIDER COMPLETES THIS SECTION:</b>			
Medical Provider - What treatment was provided for this injury (check one)	<input type="checkbox"/> First Aid	<input type="checkbox"/> Medical treatment	
Return to work: will the employee be able to return to work immediately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If no, please provide the date the employee can return to work:		<input type="checkbox"/> Full duty	<input type="checkbox"/> Restricted work
Employee can return with these specific restrictions:			
Next appointment:			
Date:		Signature:	Title: