TNC COMMUNITY STAFF INCIDENT REPORT

INJURED STAFF MEMBER'S NAME: ___________________________________

DATE OF INCIDENT: ________________ TIME OF INCIDENT: _____________

LOCATION OF INCIDENT: ____

DESCRIBE IN DETAIL EXACTLY WHAT HAPPENED. IF AN INJURY, STATE PART OF BODY INJURED.

____

____

____

____

____

INITIALS OF ANY INDIVIDUAL(S) RECEIVING SERVICES INVOLVED

____

CAN ANY ACTION BE TAKEN TO PREVENT A RE-OCCURRENCE OF THIS OR A SIMILAR INCIDENT? (CIRCLE ONE) YES NO
EXPLAIN: ____

____

NAME, ADDRESS & PHONE NO. OF WITNESS(ES) AND OTHER STAFF INVOLVED IN ACTIVITY:

____

____

***I want to be seen by TNC's workers' compensation doctor. **YES** **NO**

***I do not feel at this time that I need medical attention. _______________________
signature of employee

_________________________________DATE: _____________ TIME: _________
TITLE AND SIGNATURE OF PERSON PREPARING REPORT

_________________________________DATE: _____________ TIME: _________
SUPERVISOR'S SIGNATURE

FAX TO TNC COMMUNITY'S MAIN OFFICE WITHIN 24 HOURS, (816) 373-5787.