



ACCIDENT/INJURY REPORT FORM

INJURED PERSON

Staff
Complete Sections 1&2

Participant
Complete Sections 1&2

Visitor/Volunteer
Complete Sections 1&3

SECTION 1 (All)

_____/_____/_____
NAME DATE OF INJURY Time: _____ Mon Tue Wed Thu Fri Sat Sun
 AM PM

HUMAN RESOURCES NOTIFIED Time: _____ AM PM

WHERE ACCIDENT/ILLNESS OCCURED: _____

WHAT LED TO THE INCIDENT (*Be concise*) _____

WHAT HAPPENED (*Be concise-See Back for examples*) _____

BODY LOCACTION OF INJURY (*Select on Back of Form*)

WITNESS(es) _____ NO WITNESS

SECTION 2 (Staff & Participant Injuries)

ACTION: Sent Home Called EMS Taken to _____ BY: _____ Time _____ AM PM

FIRST AID: TYPE: BAND-AIDS ICE PACK OTHER: _____ No Treatment Required

REFUSAL OF TREATMENT

I REFUSE TO BE SEEN BY A PHYSICIAN FOR POSSIBLE INJURIES. I HEREBY DENY PALADIN THE AUTHORITY TO TAKE ME TO THE EMERGENCY ROOM OR HOSPITAL FACILITY.

_____/_____/_____
Appropriate Signature Witness Signature Date Signed

SECTION 3 (Visitor/Volunteer Information)

NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNED: _____ / _____
STAFF COMPLETING FORM DATE COMPLETED

Be as concise as possible when explaining Circumstances of the incident.

Examples:

- Was hit by a client/or object during a behavior.
- Moving materials, turned, felt pain in lower leg.
- Injured in a vehicle accident
- Cooking dinner and got burned by boiling water.

Body Location of Injury	Body Location of Injury
<input type="checkbox"/> Arm Upper Left	<input type="checkbox"/> Knee Left
<input type="checkbox"/> Arm Upper Right	<input type="checkbox"/> Knee Right
<input type="checkbox"/> Back Lower	<input type="checkbox"/> Leg Left
<input type="checkbox"/> Back Middle	<input type="checkbox"/> Leg Right
<input type="checkbox"/> Back Upper	<input type="checkbox"/> Lip
<input type="checkbox"/> Buttocks Left	<input type="checkbox"/> Neck Left Side
<input type="checkbox"/> Buttocks Right	<input type="checkbox"/> Neck Right Side
<input type="checkbox"/> Chin	<input type="checkbox"/> Nose
<input type="checkbox"/> Ear Left	<input type="checkbox"/> Not Recorded
<input type="checkbox"/> Ear Right	<input type="checkbox"/> Rib (Chest) Left Side
<input type="checkbox"/> Eye Left	<input type="checkbox"/> Rib (Chest) Right Side
<input type="checkbox"/> Eye Right	<input type="checkbox"/> Shoulder Left Arm
<input type="checkbox"/> Face Cheek Left Side	<input type="checkbox"/> Shoulder Right Arm
<input type="checkbox"/> Face Cheek Right Side	<input type="checkbox"/> Teeth
<input type="checkbox"/> Finger Left Hand	<input type="checkbox"/> Thigh Left Side
<input type="checkbox"/> Finger Right Hand	<input type="checkbox"/> Thigh Right Side
<input type="checkbox"/> Foot Ankle Left	<input type="checkbox"/> Thumb Left Hand
<input type="checkbox"/> Foot Ankle Right	<input type="checkbox"/> Thumb Right Hand
<input type="checkbox"/> Foot Left	<input type="checkbox"/> Toes Left Foot
<input type="checkbox"/> Foot Right	<input type="checkbox"/> Toes Right Foot
<input type="checkbox"/> Forearm Left Arm	
<input type="checkbox"/> Forearm Right Arm	
<input type="checkbox"/> Forehead	
<input type="checkbox"/> Hand Left	
<input type="checkbox"/> Hand Right	
<input type="checkbox"/> Head Back	
<input type="checkbox"/> Head Top	

Type of Injury
<input type="checkbox"/> Bite
<input type="checkbox"/> Break
<input type="checkbox"/> Bruise
<input type="checkbox"/> Burn
<input type="checkbox"/> Cut
<input type="checkbox"/> Hit
<input type="checkbox"/> Illness
<input type="checkbox"/> None Visible
<input type="checkbox"/> Scrap
<input type="checkbox"/> Scratch
<input type="checkbox"/> Smashed
<input type="checkbox"/> Sprain
<input type="checkbox"/> Strain
<input type="checkbox"/> Other _____

**This form is to be completed by the end of Employee's shift.
Form must be turned in to HR within 24 hours or by the next business day.**