COMMUNITY LIVING BRANT WORKER'S REPORT OF INJURY / DISEASE / VIOLENCE

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		raye i 0i 2		
Α				
	Worker's Name: Work Loc	ation:		
	Iome Address:			
	Postal Code: Home Pho	one #:		
	Current Position: Yrs. Experience in Occupation:			
ľ	Normal Weekly Hours of Work:			
ŀ	Where Did Injury / Incident Occur?			
ŀ	Time injury / Incident Occurred:			
-				
-	Will you be absent from work beyond the day of the injury?			
	Did you seek medical attention?: Yes or No	o (if yes, complete physician info.		
	below)			
	Physician's name, address and phone #:			
	Physician Recommendations: (attach functional abilities form)			
ŀ	Thyoloidin recommendation (dilatin in inclinitial abilities form)			
ŀ				
ŀ				
	If this incident/injury is a result of workplace violence, place	ass semplete section B so well so C		
	If this incident/injury is a result of workplace violence, plea			
В		ION:		
	Type of Violence:			
	□ Verbal abuse, □ threat, □ strike, □ grab, □ assault,	□ sexual assault, □ sexual abuse		
	□ Other (Describe)			
	Describe details of the incident and contributing factors (if known):			
	□ property damage to:□ staff personal property (specify)			
	person supported property (specify)			
	□ agency property			
	□ other (specify)			
	C Data of lainer / la side at	airm. / la aide at		
С		njury / Incident:		
	Date and time reported to employer:			
	Date and time you last worked on day of injury:			
	Scheduled hours of work on last day worked:			
	Describe injury: (body part involved, left or right side)			
		/ / \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
	Have you had an injury to this hady part proviously?	es or No		
	Have you had an injury to this body part previously?	es or No		

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		r age z or z		
	Describe what happened to cause the injury:			
	Who was the injury reported to:			
	Describe your activities at the time of the injury:			
	Provide name, address and phone # of witnesses:			
	A second distinct of the second secon			
	Any additional information:			
	What can be done to prevent re-occurrence?:			
	virial can be done to prevent to documence:			
	Signature of Injured Worker: Date	a:		
	Signature of injured Worker.			
SUI	PERVISOR TO COMPLETE THIS SECTION			
	nediate Action Taken (include steps taken to prevent a recurrence	7).		
	Todato From the Front Amond of the Control of the C	·/·		
Sigi	nature of Supervisor:	ate:		
Distribution: to Human Resources - immediately				