STAFF INCIDENT REPORT
CONFIDENTIAL REPORT

HUMAN RESOURCES USE		CENTRAL STATE HOSPITAL Milledgeville, Georgia	SUPERVISOR'S USE	
Facility Admin.			Teleclaim operator:	
Risk Mgmt		***MANDATORY:***	Claim #:	
Reimb. Comm.		***All incident reports must be received in Human Resources within 48 hours of incident.***	Hire Date:	
Infection Ctrl.			Salary:	

PART I: PERSONAL HISTORY (To be completed by STAFF)

Name:		Birth Date:		Race:		Sex:	
Home Address:				City:			
Emp ID #:		Unit Phone:		State:		Zip:	
Shift Begins:		Shift Ends:		Job Title:			
Assigned Unit :				Phone Ext:			
Supervisor:							

PART II: INCIDENT INFORMATION (To be completed by STAFF)

Date:		Time:		Incident Location:	
Incident Reported to:				Date:	

Describe the incident: (Who, what, where, why, and how):

Describe any injury in detail:

Witness:		Witness Phone:	
Witness:		Witness Phone:	
STAFF SIGNATURE:		STAFF PHONE:	
STAFF TITLE:		DATE:	

PART III: CATEGORIES - Check all that apply. (To be completed by Supervisor/Director)

Caused by:	Staff		Client		Other		
Victim:	Staff		Client		Other		

Type:	Accident		Assault		Burn		A & D		Fall		Reaction		Injury	
	Property		Sexual		Vehicle		Other (Specify)							

Injury Type	None		Bite		Bruise		Fracture		Laceration		
	Scratch		Swelling		Kick		Other (Specify)				

Exact Body Part (Specify Right/Left)	Abdomen		Ankle		Back		Chest		Elbow		Eye		Face		
	Feet		Head		Knee		Mouth		Neck		Shoulder		Hand		
	Other (Specify)														

PART IV: COMMENTS AND ACTIONS (To be completed by Supervisor of Origin)

First Aid Administered?		Type of First Aid			
Medical Attention required?					
Employee was advised of Network Information?		Shift Completed ?			
Returned next day?		If no, scheduled off?		Next scheduled date:	
Employee selected treatment from:					
The Georgia Activity Analysis Form should be sent to the doctor with the employee if treatment is selected.					
First date aware of incident:		Number of Days STAFF works per week			
SIGNATURE		TITLE			
DATE SIGNED					

PART V: COMMENTS AND ACTIONS (Please provide any additional information regarding the incident, i.e., weather conditions, environment, etc. and or recommendations for prevention of recurrence)

PART VI: WORKERS' COMPENSATION SELECTION OF PAYMENT OPTION (To be completed by INJURED STAFF)

Select one of the following payment options in case lost time occurs:

(101)		Workers' Compensation benefits for loss wages instead of using accrued leave. I understand I will be placed on leave without pay while I receive Workers' Compensation benefits for loss of wages. I also understand that I will not receive full pay, but will be paid 66 2/3% of my average weekly wage, but not greater than $350.00 weekly.
OR		
(102)		Use of my sick/annual and/or personal leave while absent due to my workers' compensation injury and/or illness. I understand that if I use all of my accrued leave, I will receive Workers' Compensation benefits if I am still unable to work. I also understand that I cannot receive Workers' Compensation benefits and regular salary compensation (e.g., use of accrued leave) at the same time.

Entitlement of benefits for the first seven calendar days of disability or any portion of the time requires that the employee be disabled for at least twenty-one consecutive calendar days and that the first seven calendar days were leave without pay.

I understand that all absences from work due to an injury and/or illness that qualifies as a serious health condition will be charged to available family leave.

STAFF SIGNATURE:		STAFF PHONE:	
STAFF TITLE:		DATE:	