Alliance
Physical Therapy Partners

607 Dewey Ave. Suite 300 Grand Rapids, MI 49504
**FED ID # 38-3496350** **UI # 1446562**
**SIC/NAICS: 8999**

# Associate Incident Report

## ASSOCIATE SECTION

| NAME (FIRST, MIDDLE, LAST) | SOC SEC # | BIRTHDATE | AGE | ☐ MALE ☐ FEMALE |
|---|---|---|---|---|
| | | | | |

| HOME MAILING ADDRESS | HOME PHONE # |
|---|---|
| | |

| WORK FACILITY | DEPARTMENT & POSITION/JOB TITLE |
|---|---|
| | |

| WORK ADDRESS | WORK PHONE # |
|---|---|
| | |

TAX FILING STATUS ☐ Single ☐ Single, Head of Household ☐ Married, Filing Joint ☐ Married, Filing Separate

NUMBER OF DEPENDENTS

## OCCUPATIONAL INJURY OR OCCUPATIONAL ILLNESS

| Where did the incident occur? | Date of incident | Time of incident _____☐ AM ☐ PM ☐ can't determine | Did the employee die? ☐ YES ☐ NO |
|---|---|---|---|
| | | | |

| Were you on duty? ☐ YES ☐ NO Time began work: | If NO, explain |
|---|---|
| | |

| If the incident occurred off worksite premises, were you in the course of performing regular duties? ☐ YES ☐ NO | If YES, explain |
|---|---|
| | |

Describe injury or illness in detail

| Part of body injured | If applicable, name the object or substance which directly injured you |
|---|---|
| | |

If you are alleging an occupational illness, please explain how it was contracted.

What were you doing when injured (be specific)?

How did the accident occur? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how.)

| Could it have been avoided? ☐ YES ☐ NO | If YES, explain how |
|---|---|
| | |

List any witnesses to the incident

| Were you seen by physician? ☐ YES ☐ NO **If yes attach Work Status Report from physician** | Name and address of physician |
|---|---|
| | |

| Outcome/ Disposition | ☐ Return to work ☐ without ☐ with restriction | ☐ Hospitalized | ☐ Sent home—approx. date of return: / / |
|---|---|---|---|
| | ☐ Follow-up treatment of evaluation scheduled? ☐ YES ☐ NO | | If YES, when: / / |

If hospitalized, name and address of hospital

| ASSOCIATE SIGNATURE | DATE |
|---|---|
| | |

**SUPERVISOR TO COMPLETE REVERSE SIDE**

*All medical bills related to this incident should be sent to:*
Alliance, Attention Risk Manager
607 Dewey Ave. Suite 300 Grand Rapids, MI 49504

Alliance
Physical Therapy Partners

607 Dewey Ave. Suite 300 Grand Rapids, MI 49504

# Supervisor's Incident Investigation

**WHEN**

| Date of incident | Time | Report to supervisor delayed? ☐ Yes ☐ No *If yes, why?* |
|---|---|---|
| | | |

**WHO**

| Associate's Name | Occupation |
|---|---|
| | |

FACILITY NAME (*no abbreviations*)

**INJURY/ LOSS**

| Nature / extent of injuries | Was Associate removed from work by Physician? ☐ Yes ☐ No *If Yes:* Approx. Return to Work Date: / / |
|---|---|
| | |

**DISPOSITON**

*(IN ADDITION TO OR IF NOT ON EMPLOYEE REPORT)*

☐ Return to work without restriction ☐ Return to work with restriction thru_____date
☐ Hospitalized @

☐ Follow-up treatment of evaluation scheduled? ☐ YES, DATE_____ ☐ NO

**WHERE**

Exact location where incident occurred

**WHAT/ HOW**

Type of accident: ☐ Fall/Slip ☐ Overexertion – Carry/Hold ☐ Cumulative Trauma Disorder
☐ Struck by_____ ☐ Fumes, Dust, Gas, Caustics, Noise, etc
☐ Overexertion – Push/Pull ☐ Motor Vehicle Accident
☐ Overexertion – Lift/Lower ☐ Other _____

Was associate doing something other than required duties at time of accident? ☐ Yes ☐ No *If yes, what and why?*

Description of incident *(detail what associate was doing; how he/she was doing it; any physical objects involved)*

**WHY**

**Accident Cause Analysis** *(check all that apply)*

**PERSONAL**

☐ **Bodily conditions-circle all contributing factors**
*Physical impairment; illness; fatigue; emotional upset; possible intoxication; possible impaired by drugs/medication*

☐ **Lack of skill or knowledge**
*Improperly trained; inexperienced; uninformed; unaware; etc.*

☐ **Adequate skill or knowledge, but failure in execution**
*Failure to follow policy; Chance-taking; failure to use safety devices; failure to do what should have been done in the particular situation*

☐ **Improper apparel**
*Failure to use personal protective equipment; loose clothing; jewelry; etc*

**ENVIRONMENTAL**

☐ **Inadequate safeguards**
*Lack of safety devices; lack of mechanical lift; other unsafe design*

☐ **Improper or defective equipment**
*Poorly maintained, broken, cracked, worn equipment; inappropriate personal protective equipment*

☐ **Location hazard**
*Poor layout; congestion; insufficient space; poor lighting; etc*

☐ **Poor ergonomics**
*Heavy lifting, poor workstation design; excessive bending, twisting or reaching; inadequate tools*

☐ **Poor housekeeping**
*Improper piling or placing; clutter; spillage or breakage*

**PREVENTION**

Action(s) taken to prevent/correct: *(include t dates)*

Recommendations/Additional Actions to be taken: What should be done and by whom to prevent reoccurrence of this type of incident? *(Include target dates for action)*

| **SUPERVISOR SIGNATURE** | **DATE** |
|---|---|
| | |

***To be completed by Alliance Corp Office***

Associate Hire Date_____ Date Last Worked _____ RTW Date _____

Approving Signature_____ Date _____