CDC/ATSDR INCIDENT REPORT

Reset Form

SECTION 1.

To be completed by supervisor and copy 1 delivered by employee, if possible, to the Occupational Health Clinic (OHC).
***NOTE** (Supervisors): This form shall also be completed for employees receiving outside medical treatment for occupationally-related injuries or illnesses and copy 1 forwarded to the OHC for reporting and recordkeeping in accordance with OSHA regulations.*

1. Date of Incident:	**2. Time of Incident:**	**3. Employee User ID** (e.g. xxx#):

4. Is Employee a Supervisor? ☐ **Yes** ☐ **No**	**5. Date Employed** (Effective date of employment – MM/YYYY):

6. Name:(Last, first, middle initial):

7. Home address:

City: **State:** **Zip:**

Telephone#
(Home):
(Work):

8. Social Security No.:	**9. Date of Birth:**	**10. Sex** (Check one): ☐ **Male** ☐ **Female**

11. Occupation: (Enter the regular job title, not the specific activity he/she was performing at the time of injury.)	**12. Center/Institute/Office:** (Enter the C/I/O in which the person is regularly employed even though he/she may have been temporarily working in another department at the time of injury.)
13.Location of the Incident: (Place where incident or exposure occurred, e.g. Bldg. No.; Parking Lot; Loading Dock, etc.):	**14. Was place of incident or exposure on CDC/ATSDR's premises?** ☐ **Yes** ☐ **No**

15. Vehicle Involved? (Check one): ☐ **Yes** ☐ **No**	**16. Witnesses, if any** (Name(s) in full):

17. How did the incident occur? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

18. Disposition (Check one): **NOTE:** Complete this item ***only*** for employees that did not receive treatment at the Occupational Health Clinic.

☐ **Hospital** ☐ **Private Physician** ☐ **Home** ☐ **Other** (Specify) _____

19. Supervisor's Name (Please print):	**20. Signature of Supervisor and Date:**

SECTION 2.

This section must be completed by the supervisor upon return of the employee to normal duties and copy 3 forwarded to the Occupational Health Clinic to document lost time and/or restricted activity.

21. ☐ **Check box if employee returned to work and no lost time and/or restricted activity was incurred.**

22. Lost Time: (Enter date employee stopped work. NOTE: Do not include the day the incident occurred): _____

23. Restricted Time: (Enter date employee was placed on restricted work activity, e.g., 2 hrs. on, 2 hrs. off; half day(s), limited duties): _____

24. Date Returned to Work: (Enter date employee returned to normal duties): _____

The information requested on this form, including your Social Security number, is collected under the authority of Executive Orders 12107, 12196, and 12564 and 5 U.S.C. Chapters 11, 31, 33, 43, 61, 63, and 83. The information is used by Office of Health and Safety and Occupational Health Clinic medical personnel to document circumstances of the incident or exposure which occurred. The Social Security number is being collected for identity verification purposes. Furnishing the requested information, including your Social Security number, is voluntary; however, failure to provide the requested information may make it more difficult for medical personnel to provide you with optimal care. Individually identified data will be available to authorized CDC and ATSDR personnel and may be shared with the Occupational and Safety Health Administration and the U.S. Department of Labor. An accounting of such disclosures will be made available to you upon request.

CDC 0.304 (E), Revised June 2002, CDC Adobe Acrobat 10.1, S508 Electronic Version, September 2012

Copy 1: Occupational Health Clinic (MS A-29), Copy 2: Supervisor, Copy 3: Occupational Health Clinic Upon Employee's Return To Work.

CDC & ATSDR

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