MERCY BUSINESS HEALTH SERVICES

Date: ____/ ____/ ____ Arrival Time: _____ AM / PM

Name: _____ DOB: _____ / _____ / _____ SSN: _____ - _____ -_____

Home Phone # _____ Home Address: _____

City: _____ State: _____ Zip code: _____ Marital Status: □ M □ S □ D □ W

Employer & Department: _____ Occupation: _____ Emergency Contact: _____/Relationship_____
Emergency Contact phone number: _____

Hire Date: _____ Work Phone # _____ Supervisor: _____ext. _____

Employment Status: □ FT/ Salary □ FT/ Hourly □ PT □ Temp _____ □ Other _____
(Agency Name) (Resident, Student, Contractor, etc.)

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1. ***Is This a Work-related Injury?*** □ Yes / □ No (if **no**, skip to **#2** on back of form)

If **yes**, have you or your supervisor filed an **Employee Incident Report** (EIR)? □Yes / □ No

Date of Incident: ____/____/_____ Time work day began on the date of the incident: _____ AM /PM

Time of incident _____ AM/PM Dept. & Location where Injury occurred: _____

What were you doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer entry".

What happened? Describe how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20ft"; "Worker sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

What was the injury or illness? State the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore". Examples: "strained back"; "chemical burn to hand"; "numbness and tingling in hand and wrist".

What object or substance directly harmed you? Examples: "concrete floor"; "chlorine", "radial arm saw". If this question does not apply, write N/A.

Was treatment given away from the worksite? □ Y □ N If Yes, Where? : _____
Name & Address of Healthcare Provider & Facility

Were you treated in an emergency room? □ Y □ N If Yes, Where? _____
Name & Address of Facility

Were you hospitalized overnight as an inpatient? □ Y □ N If Yes, Where? _____
Name & Address of Facility

2. ***For Non-Line of Duty Injuries / Illnesses,*** please complete the following information:

Describe what you need to be seen for: _____

_____

_____

_____

_____

Name of Your Primary Care Doctor: _____

Office phone #: _____

For Office Purposes Only:

Scanned : _____

Faxed: _____