



Client or Employee Accident/Incident Report

This form must be completed by the first staff person who witnesses, suspects, or is informed of a reportable situation. Complete all sections, sign and date it, and return to a team member at MCFI Home Care the same day the Incident occurs.

**Report all accidents, injuries, illness, incidents, and unsafe conditions to your supervisor immediately.
Please the Main Office 414-290-0050 or 888-381-5696**

Incident Date ____/____/____ Incident Time____:____ AM/PM Date completed____/____/____

<input type="checkbox"/> Accident/ Incident	<input type="checkbox"/> Alleged <u>Abuse</u> of a Client (includes physical, sexual and/or emotional abuse)	<input type="checkbox"/> Alleged <u>Neglect</u> of a Client (includes leaving a client without completing an assigned duty)	<input type="checkbox"/> Alleged <u>Misappropriation</u> of Client's property or funds, financial exploitation.
<input type="checkbox"/> Communicable Disease Probable exposure	<input type="checkbox"/> Emergency personnel (Police, Fire, EMT) have had contact with the Client	<input type="checkbox"/> Unsafe or unsanitary environment	<input type="checkbox"/> Property Loss or Damage

Client Information

Last Name _____ First Name _____

Address _____ City _____ Zip _____

Telephone # _____ Date of Birth ____/____/____

Employee Information

Last Name _____ First Name _____

Telephone # _____ Date of Birth ____/____/____ Start Date ____/____/____

Job Title _____ Supervisor Name _____

Work related injury

Did you refuse medical treatment? YES____ If yes call your supervisor/HR contact. NO____

Did you call your human resources representative? Yes No

If you are an employee leaving your shift please contact your supervisor

Location of Accident/Incident (If different)

Location Name: _____

Address _____

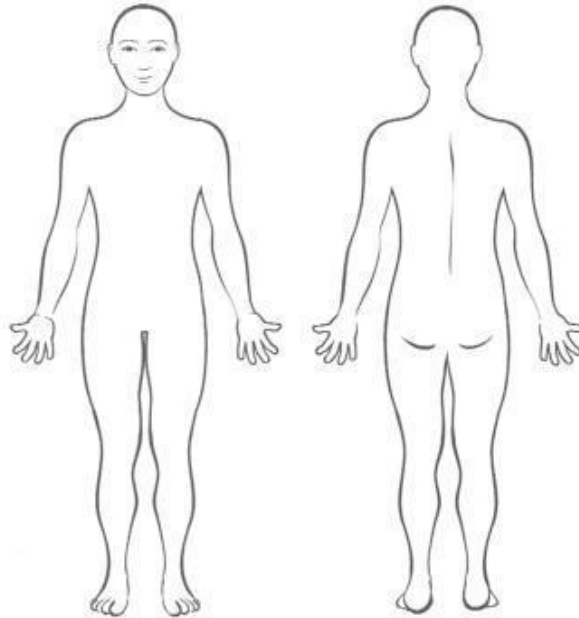
City _____ Zip _____

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Describe the details and circumstances of the situation. Answer all of the following: who, what, where, when, how, actions taken, injuries or damages, and witnesses. Only state the facts of the incident, as you observed them.

Indicate if applicable exact location of any injury (ex. left hand, ring finger).

Include drawing a picture body to assist with description



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What was the cause of the injury/incident?

Describe any damage to property or equipment

What can be done to prevent this from happening in the future?

Did the Employee/Client require medical attention?

Home *To Clinic or MD office * To emergency room via ambulance

Name of Doctor _____ Phone Number _____

Name of Clinic/Hospital _____ Phone Number _____

***If you are aware of your client leaving their home for an emergency please notify your supervisor. Indicate who and how persons were notified**

Key: TT= telephone VM= left phone message, EM= e-mail WN= written note IOM= interoffice mail DO= Taken to office directly

Person notified	Name	Date/Time	How notified	Response
Supervisor				
Human Resources				
Other:				
Other:				
Other:				
Witness Information: if applies	Name	Telephone		Address
Statement should be obtained as soon as possible.				

Attachments: Statements from all involved / witnesses

Form Completed by: _____ **Date** ____/____/____ **Time** ____:____ **AM/PM**

Employee Signature: _____ **Date** ____/____/____ **Time** ____:____ **AM/PM**

Supervisor Signature: _____ **Date** ____/____/____ **Time** ____:____ **AM/PM**

Date Received ____/____/____ Date Logged ____/____/____

Routing: Original: Supervisor – Human Resources- Manager- Director- Safety Committee-

