COMMUNITY BASED SERVICES, INC.

STAFF INJURY REPORT

Date this form completed: _____/_____/_____

1. Name of injured and job location ______________________________
2. Date & time of injury.. ______________________
3. Location where injury occurred....................................... ______________________
4. Nature of injury and body parts affected ______________________________

   ____
5. What was the employee doing when injured?______________________________
6. Describe how injury occurred ______________________________

   ____
7. Was first aid given (if yes, please explain) ______________________________

8.* a. Was outside medical treatment needed?(Name & Address of Doctor) ______________

   ____

   b. Was ER medical treatment needed?........................ ______________________

   c. Name & address of hospital ______________________________

   d. Was employee admitted? .... ______________________

9. Did injured complete workshift?...................................... ______________________

10. a. Did employee lose time from work?(List hours & days) ______________________

    b. What time did injured staff start work?...................... ______________________

11. Signature of witness to injury.. ______________________
12. Name of Administrator notified of injury .... ______________________
13. Signature of House Supervisor.. ______________________
14. **I have received a copy of the Claimant Information Packet and I understand that it is my responsibility to fill out Employee Claim and return to the Workers Compensation Board if I seek medical treatment for my injury or lose time from work beyond the date of injury.**

____

Signature of Injured

(This section will be completed by the Supervisor):

1. Was the injured person and the witness interviewed? Yes ____ No ____If so, attach summary.
2. Please document follow up, including environmental changes and/or staff training that may help to prevent a similar injury in the future.

____

____

*** NOTE: YOU MUST NOTIFY ADMINISTRATION IMMEDIATELY IF :**

1. **You incur a serious injury or illness as a result of your employment.**
2. **You need to seek medical treatment as a result of the injury or illness.**
3. **You lose any time beyond the day of the injury/illness occurred.**
4. **Once the report is submitted, HR Dept. should be notified of any further medical treatment or loss of work time related to this injury.**