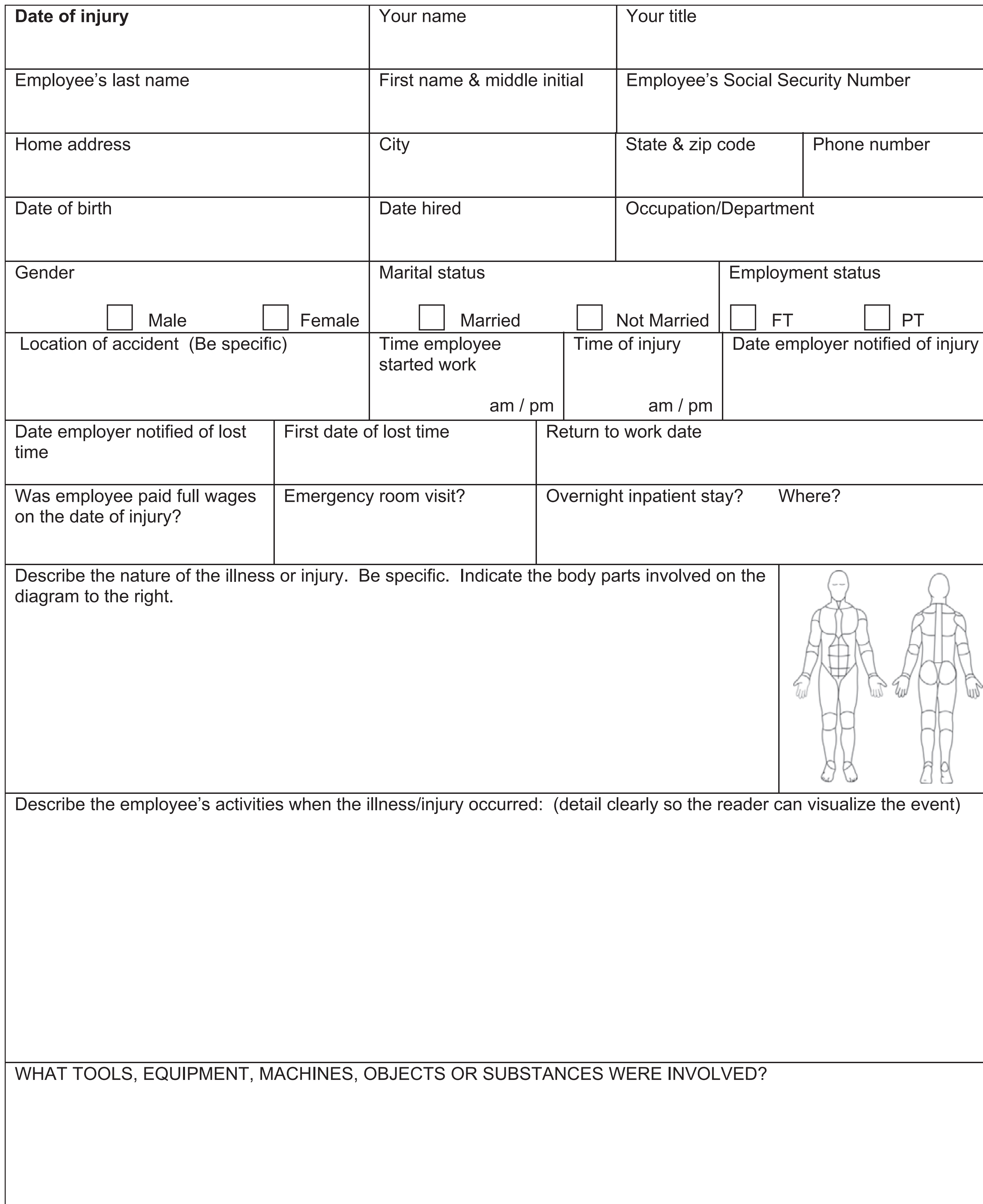
INJURY REPORT FORM

OSHA Case #_____________



Date of injury	Your name	Your title	
Employee's last name	First name & middle initial	Employee's Social Security Number	
Home address	City	State & zip code	Phone number
Date of birth	Date hired	Occupation/Department	
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Not Married	Employment status ☐ FT ☐ PT	
Location of accident (Be specific)	Time employee started work am / pm	Time of injury am / pm	Date employer notified of injury

Date employer notified of lost time	First date of lost time	Return to work date
Was employee paid full wages on the date of injury?	Emergency room visit?	Overnight inpatient stay? Where?

Describe the nature of the illness or injury. Be specific. Indicate the body parts involved on the diagram to the right.

Describe the employee's activities when the illness/injury occurred: (detail clearly so the reader can visualize the event)

WHAT TOOLS, EQUIPMENT, MACHINES, OBJECTS OR SUBSTANCES WERE INVOLVED?

PHYSICIAN AND HOSPITAL TREATMENT

Physician's name: ______________________________ Phone#:____________________

City, State, Zip Code:____

Hospital or clinic name:____

Mailing address:______________________________ City:__________________

WITNESS INFORMATION

Witness name:______________________________ Phone #__________________

Witness comments:

ACCIDENT CONDITIONS

INDOORS	**OUTDOORS**
What was the issue?	What was the issue?

ACCIDENT CAUSES

Was the wrong tool or piece of equipment used? ☐ **Yes** ☐ **No**

Was there an unsafe condition involved with the equipment or tool? ☐ **Yes** ☐ **No**

Corrective action required?: ☐ Repair ☐ Replace ☐ Other (*Describe below)*

Comments:

SURROUNDINGS			**CORRECTIVE ACTIONS RECOMMENDED**
Poor Lighting?	☐ **Yes**	☐ **No**	______________________
Poor Access?	☐ **Yes**	☐ **No**	______________________
Poor Housekeeping?	☐ **Yes**	☐ **No**	______________________
Poor Visibility?	☐ **Yes**	☐ **No**	______________________
Vehicle / Eq. Involved?	☐ **Yes**	☐ **No**	______________________

PROCEDURE

Was there a procedure associated with the task at the time of the accident? ☐ **Yes** ☐ **No**

If Yes, was it being followed correctly: ☐ **Yes** ☐ **No** (If No, explain)

Did the procedure fail to prevent the accident? ☐ **Yes** ☐ **No** (If Yes, explain how)

EMPLOYEE

Length of employment in years: ________ **years**

New employee? ☐ **Yes** ☐ **No** **If Yes, number of months employed:** ______ **months**

Was employee new to job? ☐ **Yes** ☐ **No** (if yes, how long in the job): ______________________

Was employee trained? ☐ **Yes** ☐ **No**

Did the accident involve?

☐ Horseplay ☐ Inattention ☐ Poor Judgment ☐ Unauthorized Operation ☐ Student

Explain:

Immediate corrective actions taken……...

Additional corrective actions needed?
☐ Yes ☐ No

EQUIPMENT
- ☐ Locked-Out
- ☐ Repaired
- ☐ Replaced
- ☐ Discarded
- ☐ Other

SURROUNDINGS
- ☐ Modified
- ☐ Cleaned-up
- ☐ Posted
- ☐ Evacuated
- ☐ Other

SUMMARY OF CORRECTIVE ACTIONS RECOMMENDED AT THIS TIME

Employee:

Procedure:

Training:

Equipment/tools:

Surroundings:

ADDITIONAL FACTS / INFORMATION

Were photographs taken? ☐ **Yes. Describe what the photo is of** ☐ **No**

ACKNOWLEDGEMENTS

Employee ______________________________ ______________
Signature *Date*

Supervisor ______________________________ ______________
Signature *Date*

Date reviewed by Safety Committee ______________________________

CRMC
CUYUNA REGIONAL MEDICAL CENTER
Dedicated to You. Every Day.

Authorization to Release Protected Health Information

Crosby, Longville, Baxter, Care Center and Home Health Partnership
Phone: 218-545-4466 Fax 218-546-6091

Patient Information	Name (first & last name)	Date of Birth	Phone Number
***Patient's Email Address:**			

Instructions: If **any** section is incomplete, this form may be invalid and could cause a delay in processing.

Release Information From	**Release Information To**
☒ CRMC, 320 East Main Street, Crosby, MN 56441 ☐ Other (specify facility/individual & address below, including phone / fax if known) ____________ ____________ ____________ ____________	☐ CRMC, 320 East Main Street, Crosby, MN 56441 ☒ Other (specify facility/individual & address below, including phone / fax if known) _Health Partners/Work Comp managed care Mail Stop 21106A PO Box 1369 Minneapolis, MN 55440 FAX: 952-853-8732

Purpose for Release

☐ Continued Care ☒ Work Comp ☐ Personal ☐ Legal Purposes
☐Application of Insurance ☐Disability Determination ☐ Payment of insurance
☐claim Other (details) ____________

Information To Be Released

*****Required - check all that apply***

Send all Routine Records

☒ Provider Notes, Lab, Radiology, Procedures, Test Results.

Or Send Other Records

☐ Medication List ☐ History & Physical ☐ Provider Notes ☐ Emergency Report
☐ Discharge Summary ☐ Care Center Notes ☒ Rehab Records (PT,OT,SP) ☐ Lab Reports
☐ Pathology Reports ☐ EKG's ☐ Operative/Procedure Reports ☐ HIV/Aids Testing
☐ Radiology Reports ☒ Radiology Imaging ☐ Billing Information
☒ Other (specify contents and dates) __Workability reports ____________

*All information regarding alcohol and/or drug abuse, behavioral health and psychotherapy will be released **unless you restrict** by checking below:

_____ Do not release alcohol and/or drug abuse information _____ Do not release behavioral health information
_____ Do not release Psychotherapy Records

Dates of Service: From: _Date of injury:_ To: _Present_________	Information needed by: (optional) ☐ Records Sent _______ (initial)

**** A 2 year medical history will be sent for all Continued Care or Personal Use request, unless shorter time is specified.**

Release Method / Format

For Copies: ☒ Paper ☐ MyChart ☐ *Electronic Delivery (to patient only, complete email address above)
☐ Pick up (Photo ID required) For Imaging / MRI: ☒ CD

This authorization will expire one year from the date of signing unless I indicate and earlier date or event here: ____/____/____
The authorization may be revoked at any time except to the extent that action has previously been taken. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law**. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. Copy is as good as an original.

☒ **I give permission for records created after my signature date to be disclosed.**

Patient Signature and Date are required to release records. If an Authorized Person is signing you must include legal documentation.	____________ Patient Signature ____________ Date	____________ ________ Signature of Authorized Person Date ____________ Print Authorized Person's Name ☐ *Parent of Minor ☐ Court appointed guardian/conservator ☐ Healthcare Agent