Branding Iron

Employee Incident Report

PLEASE COMPLETE ALL INFORMATION *(To be completed by Supervisor with employee)*

Your Name (please print): John O. Bakow Today's Date: 5/21/15

Date Accident Occurred: _____ _____ Time Accident Occurred: Last week to now a.m. _____ p.m.

Time you started working: 3:30 a.m. 12:00 p.m. Were you working overtime? X Yes ____ No

Your regular department: Demission Shift: ~~3~~ 1st ____ 2 2nd ____ 3rd

Date of birth: 01-01-[illegible] Date of hire: 03/06/2015

Were you performing your regular job? X Yes ____ No If not, where were you working? _____

Please describe in complete detail what happened and list equipment, tools, or machines that were involved.

Employee/Witness Statement:
My hand has been swelling up ~~[illegible]~~ when I work Dimension line.

Please check all appropriate boxes below: **Part of Body Affected**

Head

___Ear ____ right ____ left
___Eye ____ right ____ left
___Nose
___Skull
___Teeth
___Face

Upper Extremities

___Elbow ____ right ____ left
___Upper arm ____ right ____ left
___Wrist ____ right ____ left
_1_Hand ____ right _1_ left
___Shoulder ____ right ____ left
___Forearm ____ right ____ left
___Thumb ____ right ____ left
___Fingers ____ right ____ left

Trunk

___Back (Middle)
___Back (Lower)
___Back (Upper)
___Tailbone
___Chest
___Other

Lower Extremities

___Ankle ____ right ____ left
___Hip ____ right ____ left
___Knee ____ right ____ left
___Upper leg ____ right ____ left
___Lower leg ____ right ____ left
___Foot ____ right ____ left
___Toe(s) ____ right ____ left

Nature of Specific Injury

_____Abrasion (scratch)
_____Burn (chemical)
_____Electrical shock
_____Burn (thermal)
_____Contusion (bruise)
_____Strain, Sprain
_____Laceration (cut)
_____Puncture
_____Foreign body in eye

Type of Accident

_____Caught in/on/between
_____Contact w/electric current
_____Collision (vehicle)
_____Fall (floor level)
_____Fall (different level)
_____Inhalation, absorption
_____Ingestion
_____Infection
_X_Cumulative trauma (repetitive)
_____Struck against or struck by object
_____Other (please explain)
_____

Did anyone else see this happen? ____Yes* X No *If yes, indicate names _____
Did you see the Company nurse? ____Yes X No
Did you go to the Emergency Room? ____Yes X No Name of Hospital: _____
Did you see a Physician? ____Yes X No Physician Name and Phone: _____

**request statement/incident report from witnesses*

This is an accurate report of my injury or near miss.

Employee Signature: _____ Date: _____

Investigating Supervisor Signature: [signature] Date: 5-21-15

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DECLINE OF MEDICAL TREATMENT FORM

This form is only to be signed if you **do not** require medical attention in relation to your report of an on the job incident.

I, John Bakov, acknowledge that I have reported on the job incident. The facility has offered me medical attention to be administered by the facility's designated workers' compensation physician. However, at this time I feel I **do not require** medical attention and by signing this form I am stating that I can safely complete the essential functions of my job without compromising the safety of my co-workers, residents, or myself. I understand that if my condition changes in relation to this work related incident that I must notify the facility's administrator before seeking any medical attention.

By signing this form I am declining medical attention by a physician at this time.

John Bakov 5/21/15
Employee Date

5-21-15
Supervisor Date