MADISON AREA REHABILITATION CENTERS, INC.

Employee Work-Related Incident Report

Employee Name:

Date & Time of Incident:

Describe the Incident - Include information about what happened to cause this incident, the names of other individuals involved and/or witnessing the incident, any objects or machinery that were involved and any specific symptoms you feel may be a result of this incident.

Are you planning to seek medical attention?	Yes	No	
If any list two stings was still and a such stills and be writed			
If so, list treating practitioner and clinic or hospital			
Employee Signature	Date and Time		

This form is to be completed by the affected employee immediately following a workrelated incident involving a potential injury or illness, regardless of perceived severity. This form must be submitted/faxed to Human Resources upon completion.

MADISON AREA REHABILITATION CENTERS, INC.

Supervisor Work-Related Incident Investigation Report

Employee Name:

Date & Time of Incident:

Description of the incident as given by affected employee - include information about what happened to cause this incident, the names of other individuals involved and/or witnessing the incident, objects or machinery that were involved and any specific symptoms reported by the employee. Ask the employee to "re-play" the incident at the site whenever possible.

Name and address of treating practitioner and hospital/clinic :

Witness reports to be completed by :		
Contributing Factors :		
Root Cause(s) :		
Recommended Prevention Measures:		
Action Plan to Prevent Reccurance:		
Action(s) Taken on Recommendations:		
Investigator's Signature	Title	Date and Time

This form is to be completed by the Supervisor, Human Resources or assigned individual within one working day of the incident. This report must be submitted/faxed to HR upon completion.

MADISON AREA REHABILITATION CENTERS, INC.

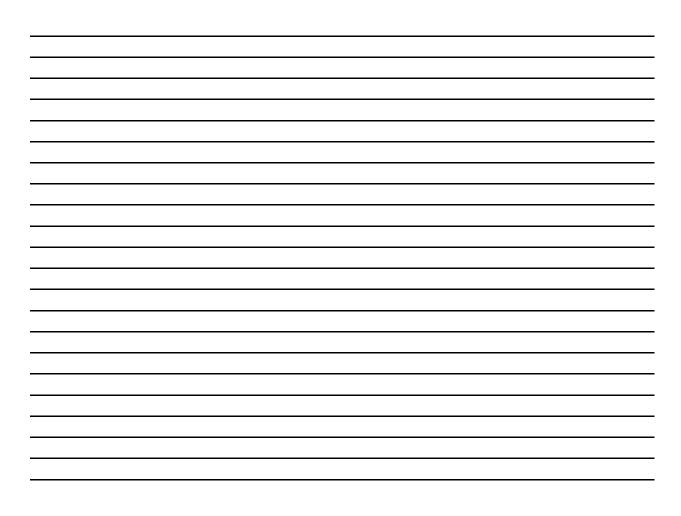
Work-Related Incident Investigation Report - Witness Statement

Employee Name:

Date & Time of Incident:

Witness Name:

Description of the incident - include information about what happened to cause this incident, the names of other individuals involved and/or witnessing the incident, objects or machinery that were involved and any specific symptoms reported by the employee directly following the incident.



Witness Signature

Title

Date and Time

This form is to be completed by each MARC employee who is present when a work-related incident occurs involving a potential injury or illness. This form must be submitted/faxed to HR upon completion.