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 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 work-related 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.

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Name and address of treating practitioner and hospital/clinic : _____

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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.

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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.