

IDF - Injury Data Form



Instructions: This form is for the collection and reporting of data associated with a work-related, injury, illness or incident. Clients must complete this entire form and submit either by email (preferred method) or signed paper copy to Infiniti HR within 24 hours of receiving notice of the injury, illness or incident. It is Infiniti HR's expectation that the following protocols be met in the event of injury or illness:

- 1) Injury, Illness or any relevant Incident will be immediately reported to Infiniti HR by submission of this form and any supporting documents
- 2) Medical care, when appropriate, will be authorized and client will assure a designated medical facility is utilized (where allowed by statute)
- 3) Client will comply with post-accident requirements (substance abuse screening, investigations, return-to-work efforts and status updates etc.)

Incident Details

1. Date of incident: (MM/DD/YY)	2. Time of incident: <input type="checkbox"/> am <input type="checkbox"/> pm	3. Date reported: (MM/DD/YY)	4. Time reported: <input type="checkbox"/> am <input type="checkbox"/> pm	5. Incident type: <input type="checkbox"/> Report Only <input type="checkbox"/> Injury - no lost time <input type="checkbox"/> Injury - lost time <input type="checkbox"/> Near Miss
6. Description of incident: (limited to 250 characters, be sure to include detail about the body part, cause, and nature of injury) <i>For example: "worker developed soreness in left wrist over time doing computer work" or "slipped and fell on wet floor breaking right leg"</i>				7. Chemical, tools, equipment, or items involved: (e.g. "boxes")
				8. Specific body part:
9. Client:		10. Address		11. Exact location of incident:
12. Incident reported to (full name):			13. Work phone: ()	14. Has incident investigation been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Person reporting incident (full name):			16. Work phone: ()	17. Incident result in fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter date:
18. Is there a witness to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Witness's full name (if more than one please attach separate page):			20. Witness's phone: ()
21. Did incident involve travel? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Was a 3rd Party Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		23. Police Report Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Details

24. Injured person's employment status <input type="checkbox"/> Employee <input type="checkbox"/> Contract Worker Other:				
25. First name of injured person:	26. Middle initial:	27. Last name:		
28. Address:	29. Work phone: ()	30. Home phone: ()	34. Start time day of injury: <input type="checkbox"/> am <input type="checkbox"/> pm	
31. Work shift (e.g. M-F 8:00am-4:30pm):	32. Does employee have second job? <input type="checkbox"/> Yes <input type="checkbox"/> No	33. Second employer name:		
34. Has injured employee missed work due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	35. First date employee missed work	36. Date employee last at work	37. Missed work on day of injury due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Date employer notified of lost time:	39. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		40. Date returned to work:	
41. Was medical treatment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	42. Emergency room visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		43. Has employee complained of similar type of injury before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
44. Medical facility's name and address: <i>(if no medical treatment please respond "None")</i>				
45. Treating physician's name: <i>(if no medical treatment please respond "None")</i>			46. Physician's phone	

Investigative Detail

47. Supervisor/Designee name:	48. Work phone:	49. Date:
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<p>Forward this form as an email attachment or by fax immediately to Infiniti HR:</p> <p>Email: sheldon@infinitih.com Fax: 240-722-0090 Phone: 866-552-6360</p> <p>Date Received</p>	<p>50. Check if "Yes" Comments:</p> <p>Is the validity of this claim in question?</p> <p>Is this a repeat injury?</p> <p>Did employee continue work after injury?</p> <p>Could this injury have been prevented?</p> <p>Any violation of safety protocols?</p>
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