MBO, P.C. INCIDENT REPORT

Complete this form in its entirety and submit within 24 hours of the incident to:
mgerhart@mbortho.com and hr@mbortho.com

File As ◯ Worker's Compensation Claim ◯ Incident Only Report	Date of Injury	Time of Injury ◯ AM ◯ PM
	Supervisor's Date of Knowledge	Worker's Compensation Department Only Date Reported to Carrier:

EMPLOYEE INFORMATION

Employee Name (Last, First)	Employee SS#	Employee Date of Hire	Employee email address
Employee Address		Home Phone	Cell Phone
Job Title Please choose from the list	Department Choose from list	Supervisor's Name	Supervisor's Email
Days Worked M-F S M T W H F S ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Hours worked per week	Start Time ◯ AM ◯ PM	End Time ◯ AM ◯ PM

INCIDENT INFORMATION

Injured Body Part Please choose	Type of Injury Please choose	Action Causing Injury Please choose	Contributing Object/Equipment

Describe in detail how the accident occurred

Did injury occur in office? ◯ Yes ◯ No	Office location where injury occurred Please choose	If not in office, name and address of the site:
Was another person responsible? ◯ Yes ◯ No	Name and contact information of responsible party:	Were other employees injured? ◯ Yes ◯ No
Name and contact information of Witness None ☐	Did the employee miss any work related to the injury? ◯ Yes ◯ No Time From:	If Yes, Date: To:

MEDICAL INFORMATION

Medical Treatment Required? ◯ None ◯ Emergency Room ◯ First Aid ◯ Hospitalization ◯ Medical Care	Medical Facility ◯ Robert Wood Johnson Hamilton ◯ St Mary Medical Center ◯ Other	If Other, please complete following: Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Safety Training Scheduled	☐ Employee Counseled ☐ Repairs Ordered	☐ Personal Protective Equipment Ordered ☐ Other:

Completed By	Signature	Date