VILLANOVA UNIVERSITY OCCUPATIONAL ACCIDENT INVESTIGATION REPORT

INFORMATION ABOUT THE EMPLOYEE:

NAME: Name (LAST / FIRST / MIDDLE) DATE OF BIRTH: MM/DD/YYYY (MONTH / DAY / YEAR)

SOCIAL SECURITY #: Click here to enter text. DATE OF HIRE: MM/DD/YYYY (MONTH / DAY / YEAR) GENDER: M ☐ F ☐

ADDRESS: Click here to enter text. (STREET ADDRESS / CITY / STATE / ZIP CODE)

HOME PHONE #: (999) 999-9999 RACE/ETHNICITY: Click here to enter text.

JOB TITLE: Click here to enter text. DEPARTMENT: Click here to enter text.

INFORMATION ABOUT THE HEALTHCARE PROVIDER:

NAME OF THE PHYSICIAN OR HEALTHCARE PROFESSIONAL: Click here to enter text.

IF TREATMENT WAS GIVEN AWAY FROM THE WORKSITE, WHEN AND WHERE WAS IT GIVEN? Click here to enter text.

BRYN MAWR HOSPITAL ☐ PENN MEDICINE ☐ VEMS ☐ OTHER ☐

WAS THE EMPLOYEE SEEN IN AN EMERGENCY ROOM? YES ☐ NO ☐ WAS THE EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? YES ☐ NO ☐

INFORMATION ABOUT THE CASE:

LOCATION/BUILDING: Click here to enter text. CASE #: Click here to enter text.

DATE OF ILNESS/INJURY: Date (MONTH / DAY / YEAR) TIME EMPLOYEE BEGAN WORK: Time TIME OF EVENT: Time AM/PM

WHAT WAS THE EMPLOYEE DOING RIGHT BEFORE THE INCIDENT?: Click here to enter text.

WHAT HAPPENED?: Click here to enter text.

WHAT WAS THE ILLNESS?: Click here to enter text.

WHAT WAS THE EQUIPMENT/MATERIALS INVOLVED THAT DIRECTLY HARMED THE EMPLOYEE?: Click here to enter text.

INFORMATION REQUIRED:

WAS PUBLIC SAFETY NOTIFIED? YES ☐ NO ☐ CONTROL #: Click here to enter text. COULD THE ACCIDENT REOCCUR? YES ☐ NO ☐

WHAT WERE THE UNSAFE ACTS OR HAZARDOUS CONDITIONS?: Click here to enter text.

CORRECTIVE ACTION REQUIRED: Click here to enter text.

WAS THE EMPLOYEE GIVEN A COPY OF THE WORKER'S COMPENSATION EMPLOYEE NOTIFICATION TO SIGN AND RETURN TO HR? YES ☐ NO ☐

SUPERVISOR SIGNATURE: Click here to enter text. DATE: MM/DD/YYYY

DEPARTMENT MANAGER: Click here to enter text. DATE: MM/DD/YYYY