DAVIS BEHAVIORAL HEALTH
Community • Commitment • Change

Workplace Injury, Accident, or Incident Data Sheet
Policy 1161887

Personal Information

Employee Name: _____ **Date Prepared:** _____
Phone #: _____ **Date of Birth:** _____
Email Address: _____ **Social Security #:** _____
Street Address: _____ **Sex:** Select...
City: _____ **State:** _____ **Zip:** _____

Employment Information

Job Title: _____ **Hire Date:** _____

Wage Information

Rate: _____ per Select... **# Days Worked/Week:** _____

Accident/Incident/Injury Information

Date of Injury: _____ **Time of Injury:** _____
Date DBH Notified: _____ **Time Work Began:** _____
Accident Premises: Select...
Region of Body: Select... **Part of Body:** Select...
Type of Injury: Select... **Side of Body:** Select...

Specifically describe accident/incident/injury and how it occurred.

Specific activity employee was engaged in when accident or illness exposure occurred.

Equipment, materials, chemical employee was using when accident/incident/injury occurred.

Work process employee was engaged in when the accident/incident/injury occurred.

Initial Treatment Information

Please provide information about the treatment you received at Intermountain WorkMed after the accident/incident/injury.

Physician Name: _____ **Phone #:** _____
Street Address: _____ **City:** _____ **State:** Utah **Zip:** _____

Other Information

Please provide information about the treatment you received at Intermountain WorkMed after the accident/incident/injury.

Witness Name: _____ **Witness Phone #:** _____