

Parkland Health & Hospital System
Injury on Duty/Occupational Exposure Report

- This report is to document information regarding an Injury on Duty/ Occupational Exposure.
- This form must be completed by the Injured Worker, Supervisor or Manager. Complete each applicable section and submit to the Workers' Compensation Department within 24 hours of the incident.
- **Do not delay reporting an Injury/Occupational Exposure if all information is not available.**

Employment and Personal Information

Employee Name _____ Date of Birth _____

Employee ID# _____ Job Title _____ Dept # _____

Gender: Male [] Female []

Address _____

City _____ State _____ Zip Code _____

Home # _____ Cell # _____ Ext.# _____

Employee's Statement

Date of Injury ____/____/____ Time of Injury _____

Patient Handling Yes [] No [] Patient's name _____

Work location of injury _____

How many hours have you been on duty prior to the incident? _____

How many consecutive days have you worked prior to the incident? _____

Include all injured body parts. Example: left or right hand. Upper, middle or lower part of the back. If necessary, page 2 has additional space to further describe Injury/Occupational Exposure.

Cause of injury/what happened? _____

Witness#1: _____ Phone# _____

Witness#2: _____ Phone# _____

Was injury result of workplace violence? Yes [] No []

Unsafe workplace reported to the Safety Officer? Yes [] No []

Employee Signature _____ Date Reported _____

Medical Provider Information

Date of first treatment for this injury: _____

Doctor's name: _____ Phone# _____

Needlestick and Occupational Exposures: Occupational Health Department receives copies of all Needlesticks and Occupational Exposures.

Clean needle [] Dirty needle [] Occupational Exposure type: _____

Patient's name: _____ MR #: _____

Supervisor/ Manager's statement

Was the Supervisor or Manager notified of this injury within 24 hours? _____
Please give a brief description of the injury.

Immediate Supervisor/Manager name _____

Extension/Pager # _____

Signature _____ Date _____

Part II: Employee's Statement: Provide any additional information regarding the injury.

Call Injury on Duty Hotline at 214- 590-1234, or extension (21234) for Instructions/Questions.

Distribution: FAX COPY: to Workers' Compensation, ext. 22715 within 24 hours
ORIGINAL: Employee Copy
BLOOD/BODY FLUID EXPOSURES ONLY: Fax to Ext 22715 and
take copy to Occupational Health