TNC COMMUNITY STAFF INCIDENT REPORT

INJURED STAFF MEMBER'S NAME: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____

LOCATION OF INCIDENT: _____

DESCRIBE IN DETAIL EXACTLY WHAT HAPPENED. IF AN INJURY, STATE PART OF BODY INJURED.

_____

_____

_____

_____

_____

INITIALS OF ANY INDIVIDUAL(S) RECEIVING SERVICES INVOLVED

_____

CAN ANY ACTION BE TAKEN TO PREVENT A RE-OCCURRENCE OF THIS OR A SIMILAR INCIDENT? (CIRCLE ONE) YES NO
EXPLAIN: _____

_____

NAME, ADDRESS & PHONE NO. OF WITNESS(ES) AND OTHER STAFF INVOLVED IN ACTIVITY:

_____

_____

***I want to be seen by TNC's workers' compensation doctor. **YES** **NO**

***I do not feel at this time that I need medical attention. _____
signature of employee

_____DATE: _____ TIME: _____
TITLE AND SIGNATURE OF PERSON PREPARING REPORT

_____DATE: _____ TIME: _____
SUPERVISOR'S SIGNATURE

FAX TO TNC COMMUNITY'S MAIN OFFICE WITHIN 24 HOURS, (816) 373-5787.

EMPLOYEE INCIDENT/INJURY REPORT

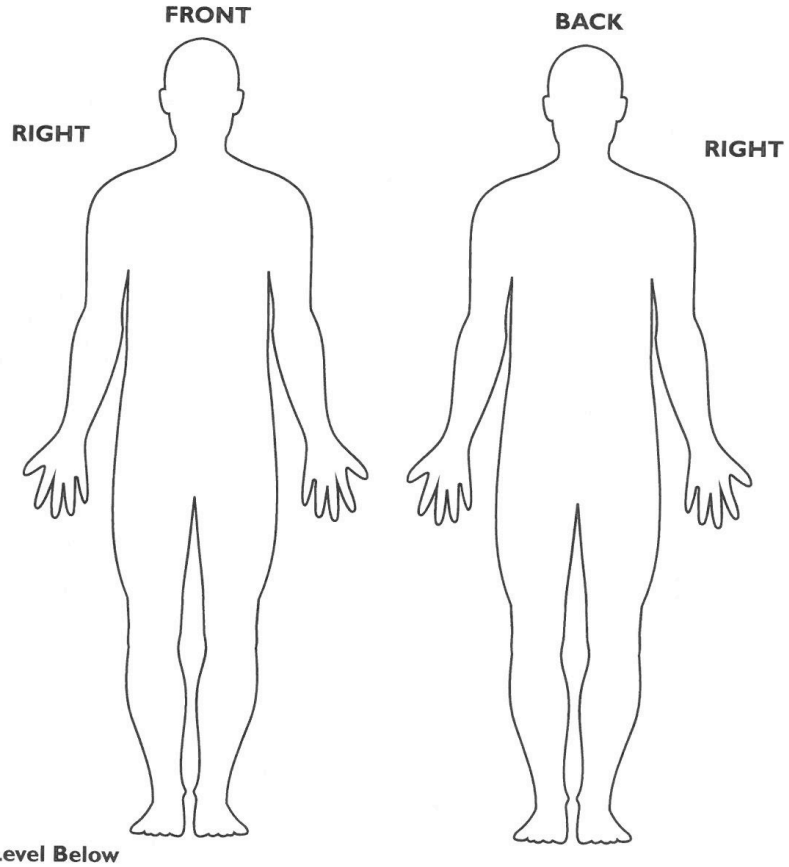
THIS REPORT TO BE COMPLETED BY INJURED EMPLOYEE.

NAME: _____ DATE: _____

DEPARTMENT: _____ JOB: _____

MARK THE AREAS OF THE BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS WITH THE APPROPRIATE SYMBOLS FROM THE CHART BELOW.

NUMBNESS	+ + + + +	SHARP	/ / / / /
BURNING	x x x x x	DULL & ACHING	* * * * *
PINS & NEEDLES	0 0 0 0 0	WEAKNESS	∇ ∇ ∇ ∇ ∇



Indicate Pain Level Below

NONE SLIGHT MODERATE SEVERE UNBEARABLE

SIGNATURE: _____ DATE: _____

WITNESS: _____ TITLE: _____ DATE: _____