LifeWays Community Mental Health

INJURY REPORT FORM

Person Injured:	☐ **LifeWays Employee**	☐ **Consumer**	☐ **Visitor**
Name of Person Injured:			
Date of Injury:	**Time of Injury:**	**Shift:**	☐ **1st** ☐ **2nd** ☐ **3rd**
Person Filling out Form:			
Location Where Injury Occurred:			
☐ **Jackson Office**	☐ **Hillsdale Office**	☐ **Other Location:**	
Other Employee(s) Involved and/or Present:			
Consumer(s) Involved or Was Another Person the Cause of Injury? ☐			
If yes, attach copy of security incident report. Please do not include the last name of consumer(s).			
How did the incident occur? Describe the activity and any equipment or materials being used:			
Did Injured Person(s) Receive Treatment?			
☐ **Report Only (No Treatment Needed)**	☐ **Declined Treatment** **Employee initial here if refusing treatment: _____**		
☐ **Treatment was Provided**	☐ **Treatment Will Be Provided or Sought**		
Describe Treatment Provided:			
Date and Time Care Given:	☐ **Serious Injury** **(Required Ambulance or Hospitalization)**	☐ **Non-Serious Injury**	
If Serious Injury, Date and Time Chief Executive Officer/Designee Notified:			
Date and Time of Notification:	**Person Notified:**		
IF AN EMPLOYEE, Were They Referred to Henry Ford Allegiance Occupational Health	☐ **Yes**	☐ **No**	
If so, did the Health Care Professional Release Employee from Care?	☐ **Yes**	☐ **No**	
If yes, a Release to Work Notice must be provided to Human Resources (HR) before injured employee can return to work.			
Did the Health Care Professional Certify Employee for Disability Beyond the Workday?	☐ **Yes**	☐ **No**	
If yes, a Copy of the Disability from Work Shift Form must be provided to HR and Supervisor.			

Supervisor's Recommendation (administrative action to remedy and/or prevent recurrence of injury):

By signing this form, the employee certifies that the information the employee has provided is true to the best of his/her knowledge.

The injured employee also agrees to submit any documentation pertaining to their eligibility to work into LifeWays Human Resources in accordance with LifeWays Operating Procedure 9-04.07 Health/Injury/Wellness:

_____	_____
EMPLOYEE SIGNATURE AND TITLE	**DATE AND TIME**
_____	_____
SUPERVISOR SIGNATURE AND TITLE	**DATE AND TIME**

Original: Human Resources
Cc: Employee's Supervisor
Facilities Director (through Governance Office)
Safety Management Administrator (through Governance Office)

Follow up action(s), including date(s), taken by Facilities Director and/or Safety Management Administrator: