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	TIME OF INCIDENT:	LOCATION OF INCIDENT:			HENRY FORD WYANDOTTE	
IE:		SOCIAL SECURITY NUMBER:	BIRTHDATE:	SEX:	HOSPITA	
TITLE:		DEPARTMENT: BE	NEFIT STATUS: SHIFT:	EXTENSION:	EMPLOYEE HEALTH	SERVICE REQUES
E ADDRESS:		CITY: ZIP:	HOME TELEPHO	NE NUMBER:	✓TYPE OF PROBLEM: CIRCLE OR SHADE AFFECTED AREA	
T HAPPENED?					☐ Aching / pain	
THAT ENED:					☐ Burning	
					☐ Numbness /	大八人 人人人 大
HAVE YOU EVER HAD THESE SYMPTOMS BEFORE? NO YES WHEN?		☐ Stiffness				
IPMENT / PRODUCT R IO \square YES WHAT?	ELATED (i.e. chemical, furnitu	re)?			☐ Other:w	The state of the s
RENT MEDICATIONS:					WAS ACTIVITY:	
RGIES:					☐ Repetitive) } } () } ()
RST PERSON INCIDENT REPORTED TO: ANY WITNESSES TO INCIDENT? (Name)		☐ Heavy				
COULD INCIDENT HA	VE BEEN PREVENTED?				Other:	
LOYEE SIGNATURE:		DATE/TIME:	SIGNATURE OF I	REFERRING SUPER	RVISOR:	DATE/TIME:
HOW DID INCIDENT H	IAPPEN?					
HOW COLIL D INICIDEN	IT HAVE BEEN PREVENTED	?				2
TIOW COOLD INCIDE!	THAVE BEEN PREVENTED	:				O □ YES □ N/A
					DER NUMBER	
WERE PROPER POLICE NO YES	CIES / PROCEDURES FOLLO POLICY #	WED? COMMENTS:				
INCIDENT / RESOLUT DATE:	ION DISCUSSED WITH EMPL BY:	OYEE? EMPLOYEE SIGNATURE:		MANAGER / S	UPERVISOR SIGNATURE:	DATE/TIME:
DIAGNOSIS / TREATM				PHYSICIA	N ORDERS:	
				DICCHAR	OF INCTRUCTIONS.	
				DISCHAR	GE INSTRUCTIONS:	
RETURN TO WORK:	PHYSICAL RESTRICTION:	FOLLOW-UP APPOINTMENT: TARGE	ET RETURN TO WORK	DATE:		
□ NO □ YES	□ NO	NO Date:		PHYSICIA	N SIGNATURE:	DATE / TII
	SSED WITH SUPERVISOR:	YES Time:		DISCHAR	GE INSTRUCTIONS DISCUSSED W	ITH PATIENT:
RESTRICTIONS DISCU		BY:			E HEALTH	
RESTRICTIONS DISCU					SIGNATURE	
					JIGNATOTIL	
					•DO NOT PHOT	OCOPY THIS FOR
□ NO □ YES	S / COMMENTS / RECOMME	INDATIONS:			20 1101 11101	
□ NO □ YES	S / COMMENTS / RECOMME	ENDATIONS:			20	
□ NO □ YES	S / COMMENTS / RECOMME	ENDATIONS:				
□ NO □ YES	S / COMMENTS / RECOMME	ENDATIONS:				
□ NO □ YES	S / COMMENTS / RECOMME	ENDATIONS:				
□ NO □ YES	S / COMMENTS / RECOMME	ENDATIONS:				

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ATE OF INCIDENT: TIME OF INCIDENT:	LOCATION OF INCIDENT:		Henry Ford Wyandotte		
ME:	SOCIAL SECURITY NUMBER: BIRTHDATE: SEX:		HOSPITAL EMPLOYEE HEALTH SERVICE REQUEST		
B TITLE:	DEPARTMENT:	BENEFIT	STATUS: SHIFT:	EXTENSION:	✓TYPE OF PROBLEM:
DME ADDRESS:	CITY:	ZIP:	HOME TELEPHONI	I E NUMBER:	CIRCLE OR SHADE AFFECTED AREA
HAT HAPPENED?					☐ Aching / pain
					□ Burning □ Numbness
IEN DID YOU FIRST NOTICE SYMPTOMS?	HAVE YOU EVER HAD THESE	E SYMPTOM	S BEFORE?		☐ Stiffness
UIPMENT / PRODUCT RELATED (i.e. chemical, furniture	NO YES WHEN?				□ Other:
NO YES WHAT? RRENT MEDICATIONS:					
LERGIES:					WAS ACTIVITY:
IRST PERSON INCIDENT REPORTED TO: ANY WITNESSES TO INCIDENT? (Name)			☐ Heavy		
W COULD INCIDENT HAVE BEEN PREVENTED?					☐ Other:
IPLOYEE SIGNATURE:	DATE/TIME:	Ι	SIGNATURE OF RE	FERRING SUPER	
HOW DID INCIDENT HAPPEN?					
HOW COULD INCIDENT HAVE BEEN PREVENTED?					
HOW COULD INCIDENT HAVE BEEN FREVENTED!					
				WORK OR	DER NUMBER
WERE PROPER POLICIES / PROCEDURES FOLLOW ☐ NO ☐ YES POLICY #					
INCIDENT / RESOLUTION DISCUSSED WITH EMPLO DATE: BY:	YEE? EMPLOYEE SIGNATUR	RE:		MANAGER / SI	UPERVISOR SIGNATURE: DATE/TIME:
			建雄 腺	PHYSICIAN	N ORDERS:
taning the stands of the stands		The Car			
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رون با هم من المراجع ا المراجع المراجع المراجع المراجع المراجع		16,000		DISCHARG	SE INSTRUCTIONS:
City of the Marie Control of t	ر مداروا داده کوران داده کار مداروا داده داروا است داده در دروا است کاروای داده در دروا است در دروای دروای دروای دروای دروای است	1126	11.		
RETURN TO WORK: PHYSICAL RESTRICTION:	FOLLOW-UP APPOINTMENT:		TUBN TO WORK D		
NO ☐ YES ☐ NO	□ NO Date:	TARGET RE	TURN TO WORK DA		
				PHYSICIAN	N SIGNATURE: DATE / TIMI
	☐ YES Time:				
□ YES (see above) RESTRICTIONS DISCUSSED WITH SUPERVISOR: □ NO □ YES DATE / TIME:	☐ YES Time:			DISCHARG	EE INSTRUCTIONS DISCUSSED WITH PATIENT:
RESTRICTIONS DISCUSSED WITH SUPERVISOR:	•			EMPLOYER	E HEALTH
RESTRICTIONS DISCUSSED WITH SUPERVISOR:	•			EMPLOYER	
RESTRICTIONS DISCUSSED WITH SUPERVISOR:	BY:			EMPLOYER	E HEALTH
RESTRICTIONS DISCUSSED WITH SUPERVISOR: NO YES DATE / TIME: MANAGER'S ANALYSIS / COMMENTS / RECOMMENT	BY:			EMPLOYER	E HEALTH
RESTRICTIONS DISCUSSED WITH SUPERVISOR: NO YES DATE / TIME: MANAGER'S ANALYSIS / COMMENTS / RECOMMENT	BY:			EMPLOYER	E HEALTH
RESTRICTIONS DISCUSSED WITH SUPERVISOR: NO YES DATE / TIME: MANAGER'S ANALYSIS / COMMENTS / RECOMMENT	BY:			EMPLOYER	E HEALTH
RESTRICTIONS DISCUSSED WITH SUPERVISOR: NO YES DATE / TIME: MANAGER'S ANALYSIS / COMMENTS / RECOMMENT	BY:			EMPLOYER	E HEALTH
RESTRICTIONS DISCUSSED WITH SUPERVISOR: NO YES DATE / TIME:	BY:			EMPLOYER	E HEALTH
RESTRICTIONS DISCUSSED WITH SUPERVISOR: NO YES DATE / TIME: MANAGER'S ANALYSIS / COMMENTS / RECOMMENT	BY:			EMPLOYER	E HEALTH