Bridgewater College
EMPLOYEE OCCURRENCE REPORT (EOR)

EMPLOYEE TO COMPLETE ITEMS (1, 3-16)
(INCLUDE ACCIDENTS, ILLNESSES, OR EXPOSURE TO HAZARDOUS SUBSTANCE)

(1) Facility

☐ FULL TIME ☐ PART TIME ☐ PRN

EMPLOYEE NAME

ADDRESS

CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER HOME TELEPHONE

JOB TITLE WORK TELEPHONE

(2) REPORTING AREA	(3) DATE HIRED	(4) SEX	(6) OCCURRENCE DATE
CODE _____ Claim Coordinator to compare Items 2 and 2(A)		☐ Male ☐ Female	_____ DAY OF WEEK Sunday
(2A) DEPARTMENT	(3A) DATE ENTERED CURRENT POSITION	(5) AGE	(7) OCCURRENCE TIME
		(5A) DOB	: AM

(8) DATE REPORTED TO SUPERVISOR

(8A) REPORTED TO

(9) GENERAL LOCATION OF OCCURRENCE
☐ Facility Premises
☐ Office/Where _____

(10) LOCATION OF OCCURRENCE (I.E. DEPT., FLOOR, ETC.)

(11) NATURE OF INJURY
- ☐ No Apparent Injury
- ☐ Burn
- ☐ Carpal Tunnel/Cum. Stress Dia.
- ☐ Contusion/Bruise
- ☐ Dermatitis
- ☐ Electrical Shock
- ☐ Foreign Body
- ☐ Fracture
- ☐ Infectious/Other Exposure
- ☐ Laceration/Abrasion
- ☐ Puncture/Needle Stick
- ☐ Respiratory Disorder
- ☐ Strain/Sprain
- ☐ Other/Explain _____

(12) PART OF BODY

	Left	Right
☐ Arm	☐	☐
☐ Shoulder	☐	☐
☐ Elbow	☐	☐
☐ Lower Arm	☐	☐
☐ Wrist	☐	☐
☐ Hand	☐	☐
☐ Fingers	☐	☐
☐ Back	☐	☐
☐ Cervical	☐	☐
☐ Thoracic	☐	☐
☐ Lumbar	☐	☐
☐ Chest	☐	☐
☐ Head	☐	☐
☐ Ear	☐	☐
☐ Eye	☐	☐
☐ Mouth	☐	☐
☐ Nose	☐	☐
☐ Internal Organs	☐	☐
☐ Leg	☐	☐
☐ Hip	☐	☐
☐ Thigh	☐	☐
☐ Knee	☐	☐
☐ Ankle	☐	☐
☐ Foot	☐	☐
☐ Toe	☐	☐
☐ Neck	☐	☐

☐ Other/Explain _____

(13) Previous Injury, same part? ☐ Yes ☐ No

Date _____

Describe _____

(14) POSSIBLE CAUSE(S)
- ☐ Burn by _____
- ☐ Electrical Shock
- ☐ Exposure (Body Fluid, Contagious Disease)
- ☐ Chemical/Hazardous Materials
- ☐ Motor Vehicle
- ☐ Puncture by Needle/Sharps
- ☐ Slip/Fall
- ☐ Strain/Sprain due to _____
- ☐ Strike Against/Stepped On _____
- ☐ Struck/Injured by _____
- ☐ Other/Explain _____

MR of SOURCE PATIENT _____

(15) WITNESSED BY

NAME _____ HOME PHONE ( ) -

ADDRESS _____

(15A) WITNESSED BY

NAME _____ HOME PHONE ( ) -

ADDRESS _____

(16) DESCRIPTION OF OCCURRENCE

EMPLOYEE SIGNATURE DATE / /

*** * * SUPERVISION/MANAGEMENT TO FILL IN ALL ITEMS BELOW (17-22) * * ***

(17) PREVENTATIVE ACTION TAKEN

(18) TREATMENT
- ☐ Refused Treatment
- ☐ No Treatment Necessary
- ☐ First Aid
- ☐ By Employee Health
- ☐ By Occupational Health
- ☐ By Emergency Room
- ☐ Other (Explain) _____

Briefly Describe Treatment _____

Rendered By _____

(19) Referred To Panel Physician ☐ Yes ☐ No

Name _____

Treating Facility

Address _____

(20) OCCURRENCE RESULTS
- ☐ Returned to Work (RTW)
- ☐ Released to Home
- ☐ Hospitalized _____ Name of Hospital
- ☐ Fatality
- ☐ Other (Explain) _____

(21) Time Lost ☐ No ☐ Yes _____ Estimated Absence (Days)

(22) MANAGEMENT REVIEW

	SIGNATURE(S)	DATE
SUPERVISOR	_____	/ /
EHN/OHN	_____	/ /
SAFETY MANAGER	_____	/ /
ADMINISTRATION	_____	/ /