CHESAPEAKE
MEDICAL STAFFING

2401 York Road
Timonium, MD 21093
Phone (410) 321.4267
Fax (410) 321.4980

Incident / Injury Report Form

*If you are reporting an on the job injury and have not yet spoken with a Medcor Nurse,

Please STOP and call them NOW at 1-800-775-5866.

Complete and return this form after you have spoken to a Medcor Nurse*

This incident report must be completed and sent to the CMS office as soon as possible following the injury.

Fax to 410-321-4980 or email to benefits@cms24-7.com.

If you are unable to complete this form yourself, please ask your clinical supervisor to assist you, or call our office at 410-321-4267 and someone can assist you with completing the form.

If applicable for employee injury, once your incident/injury report has been reported to our Worker's Compensation Administrator, you will be assigned a claim number. We will provide you with this number in case you need it for any treatment purposes.

Chesapeake Medical Staffing's preferred provider is **Concentra**. Treatment provided by **Concentra** will automatically be sent to our Worker's Compensation Administrator for direct payment. If you receive treatment somewhere other than Concentra, please forward any bills or invoices you receive due to the incident/injury to the CMS benefits department via email at benefits@cms24-7.com. The actual invoice may be necessary for reimbursement from our insurance company, so please keep all original bills and receipts. Please note: you must be evaluated by Concentra if you are treated somewhere else, unless your work assignment location is more than 50 miles from a Concentra facility.

Printed Employee Name: _____ Certification _____

Are you reporting an incident ☐ or on-the-job injury ☐?

Date of incident/injury: _____ Time of incident/injury: _____

Did this incident / injury occur in a facility ☐ client's home ☐ or in the CMS office ☐?

Name of Facility / Client where incident / injury occurred: _____

Address of Facility / Client where incident / injury occurred: _____

_____

If the incident /injury occurred in a facility, on which unit did the incident/injury occur:_____

- Describe the incident/injury in detail: (including events that occurred immediately before)

  _____

  _____

- Describe the cause of the incident/injury, including any environmental factors that may have lead to the incident/injury: _____

_____

_____

- If applicable, identify bodily injury sustained: _____

_____

- Was a patient involved in incident? Yes ☐ No ☐
    - If so, name of patient: _____
- If this occurred in a facility, first and last name of on-site supervisor at time of incident/injury:

_____

- Full name(s) and job function(s) of witness(es): _____

_____

_____

- To whom did you report the incident/injury: _____
- Did you speak with a Medcor Nurse: Yes ☐ No ☐ Not at this time ☐
    - If yes, what was their suggestion for care of the injury: _____

      _____
- Did you seek medical attention: Yes ☐ No ☐ Not at this time ☐
    - If yes, did you go to Concentra for treatment or evaluation: Yes ☐ No ☐

      If yes, which Concentra location did you go to: _____
        - If no, please provide:
            - Name of treating physician:_____
            - Phone #:_____
            - Address: _____
    - If yes, did the provider determine a return to work date: Yes ☐ No ☐
        - If yes, what is the return to work date: _____

Signature of Employee:_____ Date:_____

Signature of CMS Manager:_____ Date Received:_____