CHESAPEAKE
MEDICAL STAFFING

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

Incident / Injury Report Form

Please call a Medcor phone triage nurse at 1-800-775-5866 pior to completing this form

As an employee of Chesapeake Medical Staffing, you have the right to report any work related incident or injury, and may be entitled to certain benefits if this occurs. We encourage employees to report any workplace incident or injury as soon as possible. Our benefits team will be able to outline the steps you should take and what benefits you may be entitled to. You will never face retaliation or negative consequences for reporting any workplace incident or injury. Any time you miss from work for a workplace injury or incident will not count as an occurrence against you. **This incident report must be completed and sent to the CMS office immediately following the incident or injury.**

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.

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, please provide:
    - Name of treating physician:_____
    - Phone #:_____
    - Address: _____
    - 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:_____

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

It may be determined that you are eligible for Workers Compensation benefit based on the circumstances of your incident or injury. Please contact the CMS benefits department via email at benefits@cms24-7.com with any questions regarding this.