Capital Area Health Consortium
270 Farmington Avenue - Suite 352 Farmington, CT 06032-1994
Phone: 860-676-1110
FAX: 860-676-1303

CCMC
Notification of Work Related Injury/Exposure For Medical Residents/Fellows

***Please complete entire form and FAX to:**
Capital Area Health Consortium - 860-676-1303

(☐) Initial Visit
(☐) Follow-up Visit

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PERSONAL DATA

Name (print): _____ DOB: _____

Program: _____ Cell Phone: _____

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INJURY RELATED DATA

Describe injury/exposure:_____

_____

Date injury/exposure occurred: _____ Time injury/exposure occurred: _____ a.m. _____ p.m.

Site (hospital, clinic) and **location**, (OR, ED, etc.) where incident occurred: _____ **(Very important)**

Part of body injured (right leg, back, left index finger, etc.): _____

Object causing injury (door, needle, etc.): _____ If needle, type and brand name if known: _____

If a "sharp", was it contaminated? Yes (☐) No (☐)

Was source patient tested? Yes (☐) No (☐)

Was source patient high risk? Yes (☐) No (☐)

Did the employee receive medical treatment other than first aid (i.e., meds, x-rays)? Yes (☐) No (☐)

If yes, what was administered? _____

Was a prescription ordered? If so, name of medication? _____ Yes (☐) No (☐)

Did the employee lose time? Yes (☐) No (☐)

If restricted duty, type of restriction? _____

Was a chart started? Yes (☐) No (☐)

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Date:_____ Date Faxed to CAHC: _____

_____
Attending Practitioner's Signature

Time:_____ Name of Sender (print): _____

_____ Contact's Phone #: _____
PRINT

I authorize information regarding this incident to be released to my employer (Capital Area Health Consortium) and their insurance carrier.

Date:_____

_____
Resident/Fellows Signature

Time:_____

_____
PRINT