

**Capital Area Health Consortium**

270 Farmington Avenue - Suite 352 Farmington, CT 06032-1994

Phone: 860-676-1110

FAX: 860-676-1303

**Hospital of Central Connecticut**

**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