

Capital Area Health Consortium

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

Phone: 860-676-1110

FAX: 860-676-1303

Hospital for Special Care

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