Capital Area Health Consortium

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

UConn Employee Health/UConn John Dempsey Hospital
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

PERSONAL DATA

Name (print): ____________________ DOB: ____________________

Program: ____________________ Cell Phone: ____________________

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 ( )

____
Attending Practitioner's Signature

Date:__________

Time:__________

Date Faxed to CAHC: ____________________

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