



# Supplemental Medical Form

Injured Employee: \_\_\_\_\_ Title: \_\_\_\_\_

Dept./Division: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Incident Date/Time: \_\_\_\_\_ Location: \_\_\_\_\_

Was an Incident Analysis Form (IAF) Completed?  Yes  No, but will soon.  
Has an 801 been completed?  Yes  No, but will soon,  N/A

### Treatment

**CALL RISK ASAP!** →  Fatality  Overnight Hospitalization  
Call RISK 24 hrs. →  Biological Exposure or needle stick  
Complete 801 →  ER  Urgent Care  Dr. Visit  Lost Time  Modified Duty  
IAF Only →  MedExpress  Report Only – no injury

### Body Part Affected (Check all that apply)

Left  Right  Head  Face  Eye  Mouth  Neck  Shoulder  
 Arm  Wrist/Hand  Finger  Chest  Abdomen  Hip/Groin  
 Upper Back  Lower Back  Leg  Knee  Ankle  Foot/Toe  
 OTHER: \_\_\_\_\_

### Injury Type

Sprain/Strain  Contusion  Laceration  Fracture  
 Burn  Eye Injury  Hearing  Concussion  
 Needle stick  Biological Exposure  Occupational Disease  
 OTHER: \_\_\_\_\_

### Task(s) that led to injury (Check all that apply)

Lifting  Carrying  Push/Pull  Reaching  Bending  Twisting  
 Climbing  Walking  Running  Operating  Driving  Handling  
 OTHER: \_\_\_\_\_

### Other involved Factors (Check all that apply)

Housekeeping  Repetitive Use  Equipment Failure  
 Chemical Use  Environment  Material Handling  
 Weather  Lack of PPE/Safety Equip.  Lock Out/Tag Out  
 Fatigue  Animal  Tool Use  
 Other Person/Liable Party  Self-rescue  Rescue  
 OTHER: \_\_\_\_\_

Include any additional relevant information not included on the IAF form.

Completed By: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_