

Ardmore Enterprises, Inc.

ILLNESS/INJURY REPORT

[Note: Use *Employee's First Report of Injury* for worker's compensation incidents]

Name of Injured Person: _____

Date & Time Injury Occurred: _____ AM PM

Date & Time Injury Noticed: _____ AM PM

Date & Time Reported: _____ AM PM

Report Prepared by: _____
(name and title)

Signs and symptoms of injury/description:

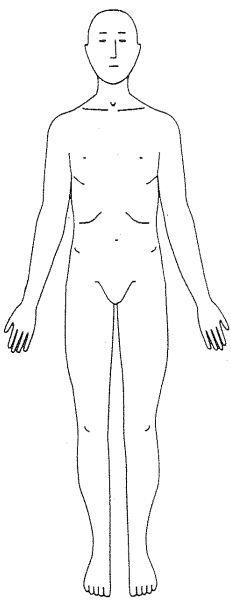
Apparent Cause of Illness/Injury:

Has this Illness/Injury occurred before? Yes No Approximate date of last occurrence _____

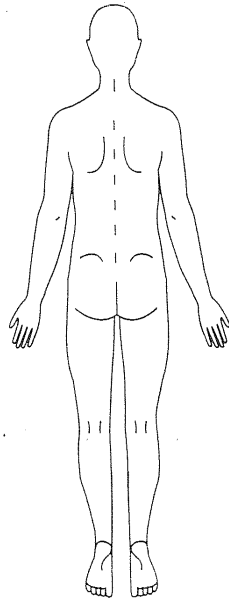
Place (setting/location) where injury occurred or noticed:

Degree of Illness/Injury: (Please indicate approximate location of *injury* below):

Minor Mild Moderate Severe Serious (requires immediate medical attention)



FRONT



BACK

First Aid or Other Tx:

Follow-up Needed:

Notified: Agency Nurse _____
 Day Coord. _____
 Res. Coord. _____

Incident Report Required? Yes No (If yes, attach)

Others Notified: Family OHCQ DSS/APS
 Resource Coord. MDLC DDA/SMRO

Other _____