SYEP Intern Incident Report

Fax Report
Attention: Barbara Mincy
863-291-6979

PARTICIPANT

Worksite ID#: SYIP PY24-25 (Name of Worksite):_____

Name (Last, First, Middle)	**Date of Birth**	**SS# (Last 4)**	**Program Start Date**	**Program End Date**

Address	**Sex:** ____Male ____Female	**Marital Status** __ Unmarried __ Married __ Separated __ Unknown	**Occupation Job Title**
Phone	**# Dependents**		

OCCURRENCE

Time work began _____ am ____ pm	Date of Injury/illness	Time of Injury: ____ am ____ pm	First Date of Disability

Type of Injury (contusion, fracture, etc.)	Body part affected (included left, right, front or back)

How injury occurred? Describe the sequence of events. Include any objects or substances that directly injured the employee, specific activity employee was engaged in when accident or illness occurred. Use reverse, if necessary.

Was supervisor notified initially? _____ Yes ____ No If no, who?	Date notified:

Witness (name & phone#)	Supervisor (name & phone)

Date prepared:	Preparer's name:	Phone#:
Date return to internship:	If fatal, date of death:	Were safeguards provided? ___Yes ___No Were safeguards used? ___ Yes ___No

MEDICAL

Health Care Provider (name & address)	Hospital (name & address)	Initial treatment: __ No medical treatment __ Minor by employer (First Aid) __ Minor Clinic Hospital Emergency Case: __ Hospitalized > 24 hrs.

OTHER

Work Week: _____ Hours _____ Days		

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CareerSource Polk Staff	Date Received:
Copy of Report Provided to: _____	Date Provided: