

LOUISIANA STATE UNIVERSITY MEDICAL CENTER - Shreveport

ON-THE-JOB INJURY RECORD

- Needlestick
- On the job injury
- Illness
- Exposure to Infectious Disease
- Other (list) \_\_\_\_\_

Name: \_\_\_\_\_ Classification: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Department: \_\_\_\_\_ Work Location: \_\_\_\_\_  
Hospital Number: \_\_\_\_\_ Location of Incident: \_\_\_\_\_  
Describe illness or incident in detail (to be completed by supervisor): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Needlestick or Mucous Membrane Exposures:

Patient source name and number: \_\_\_\_\_  
Time incident occurred: \_\_\_\_\_ (Month/Day/Year) \_\_\_\_\_ (Time) Time incident reported: \_\_\_\_\_ (Month/Day/Year) \_\_\_\_\_ (Time)

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

I hereby authorize any physician, hospital, or other medically related facility, insurance company or other organization, institution, or person to release to the University or to any of its insurers or their representative any records or information relating to my claim or any facts concerning the injury, illness or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Comments and Recommendations: (i.e., Return to work immediately; off 1 day; off 1 week, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date and Time Seen: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Nurse's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date and Time Seen: \_\_\_\_\_

Time Left Clinic: \_\_\_\_\_