Employee Paper Event Form
(to be used during system downtime)

Employee Information

Last Name:	First Name:
❑Male	❑Female

Employee Department (please choose one):

❑administration	❑Child Care	❑Dietary	❑Facilities/Maintenance	❑Health Services
❑Housekeeping	❑Laundry	❑Other	❑Security	❑ Transportation

Job Title:

If there was an Injury, complete this section

Degree of Injury

❑No Injury, no treatment required
❑Slight Injury, no treatment required
❑Mild Injury, First Aid Required
❑Moderate Injury, Treatment Required
❑Possible Injury, Sent to ER/Hospital
❑Severe Injury, Treatment/Hospitalization Required
❑Death

Location of Injury on Body:

Nature of Injury (circle)

Abrasion, adverse reaction, aggravation of pre-existing condition, allergic reaction, anaphylaxis, bite-animal, bite-human, bite-insect, bleeding/hemorrhage, blister, blister-friction, bruise/contusion, burn, cardiopulmonary arrest, chipped tooth, crush, death, dehiscence, dislocation, eardrum puncture, electrocution, emotional distress, excoriation, exposure to body fluids, exposure to other, hazardous material, foreign body, fracture, head injury, hypoglycemia, hypotension, infection, inflammation, laceration/cut/tear, loss of consciousness, loss of limb/appendage/amputation, no injury, open lesion, other skin disease/disorder, others, pain, poisoning, possible, fracture, puncture, rash, respiratory condition/distress, scald, scratch, soft tissue injury, strain/sprain, swelling

Was Employee seen in ER/Treatment Facility

❑No ❑Unknown ❑Yes: List name of Facility

Was Employee Hospitalized Overnight as Inpatient

❑No ❑Unknown ❑Yes

Was Employee Seen by a private MD

❑No ❑Unknown ❑Yes: Physician Name:

Equipment Involved/Malfunction

❑Unknown ❑No ❑Yes, please list:

Event Details

Event Date:	Event Time:

Shift ❑Day ❑Evening ❑Night ❑not applicable/unknown

General Location/Event Location (please be as specific as possible – complete as though you are creating this in PEER)

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Prepared By:	Entered Date:	Reported Date:	Reported Time:

Name of Reporter:

❑Affiliate	❑Agency Rep	❑CNA/STNA/GNA	❑Companion/Aide
❑Employee (general)	❑Family	❑LPN	❑Manager/Dept Head
❑Med Aide	❑Nurse	❑Other	❑PCA
❑Pharmacist	❑Physician - Attending	❑Power of Attorney	❑Provider Employee
❑Resident/Member/Client	❑Resident Assistant	❑Responsible Party/Guardian	❑RN
❑Student nurse	❑Visitor	❑Volunteer	

Witness Name:	Witness Phone:	Witness Type (use list above):

Specific Event Details:

❑ bite	❑ burn	❑ caught in/on/or between
❑ complaint/concern	❑ COVID-19	❑ electrical current
❑ exposure/inhalation	❑ fall/slip/trip	❑ illness at work
❑ motor vehicle accident	❑ needlestick	❑ other sharps issue
❑ overexertion	❑ resident sexual aggression/exposure	❑ resident unpredictable/aggressive
❑ skin tear/cut	❑ strain/sprain	❑ struck against/contact with
❑ struck by/contact by	❑ other	

Contributing Factors:

Description of Environment, if checked:

Reported Event Severity

❑Security Level 1-No Harm/Damage	❑Security Level 3-Serious Injury/Damage
❑Security Level 2-Temporary Minor Harm/Damage	❑Security Level 4 – Death

Event Description:

Briefly describe the event that occurred or unsafe condition: