Bloodborne Pathogens Post Exposure Checklist/Packet

_____Determine type of exposure

_____If contaminated needle stick- you should let it bleed freely, then clean exposed area with soap and water and provide any needed first aid care.

____Blood/OPIM in direct contact with the surface of the eye, nose, or mouth, you should flush the area for 10 minutes with water

____Blood/OPIM in direct contact with an open area of the skin cuts with a sharp object covered with Blood/OPIM

____Human bites/ blood drawn- let it bleed freely, then clean exposed area with soap and water and provide any needed first aid care.

_____The injured employee/responder shall report blood borne pathogen exposures promptly to their Department's Designated Infection Control Officer, if unable to reach them contact Heather Howes, on 443-684-8986.

_____ Notify receiving hospital and request that the source be tested for HIV, HBV, and HCV.

_____It should be noted on the eMEDS patient care report that there was a provider exposure incident involving this patient.

_____Complete the Consent/Refusal for HIV, HBV, and HCV of Treatment form and Incident Report for Employee form, Workmen Comp forms.

_____Post-exposure evaluation and follow-up will be advised by the Designated Infection Control Officer.

Post-exposure evaluation and follow-up

Exposure Incident Occurs

▼

Employee
Reports Incident to Employer

►

Employer
Directs Employee to HCP

Sends to HCP:

- Copy of Standard Job Description of Employee
- Incident Report (Route, etc.)
- Source Patient's Identity and HBV/HIV Status (if known)
- Employee's HBV Status and Other Relevant Medical Information

►

Healthcare Professional (HCP)
Evaluates Exposure Incident

Arranges for Testing of Exposed Employee a Source Patient (if not known already)

Notifies Employee of Results of All Testing

Provides Counseling

Provides Post-Exposure Prophylaxis, if medically indicated

Evaluates Reported Illnesses

(Items above are CONFIDENTIAL)

▼

Sends (Only) the HCP's Written Opinion to Employer:

- Documentation that employee was informed of evaluation results and th need for any further follow-up; and
- Whether HBV vaccine was received

◄

Receives HCP's Written Opinion

▼

Provides Copy of HCP's Written Opinion to Employee (within 15 days of completed evaluation)

◄

Receives copy of HCP's Written Opinion

Calvert County Infection Control
Blood and Body Fluid Exposure Report Form

Name of exposed worker: Last _____ **First:** _____ **SS#** _____

Date of exposure: _____ **Time of exposure:** _____

Job title/occupation: _____ **Department/work unit:** _____

Location where exposure occurred: _____

Name of person (if other than exposed worker) completing form: _____

Section I. Type of Exposure *(Check all that apply.)*

☐ **Percutaneous (Needle or sharp object that was in contact with blood or body fluids)**
(Complete Sections II, III, IV, and V.)

☐ **Mucocutaneous** ***(Check below and complete Sections III, IV, and VI.)***
___ **Mucous Membrane** ___ **Skin**

☐ **Bite** ***(Complete Sections III, IV, and VI.)***

Section II. Needle/Sharp Device Information

(If exposure was percutaneous, provide the following information about the device involved.)

Name of device: _____ ☐ Unknown/Unable to determine

Brand/manufacturer: _____ ☐ Unknown/Unable to determine

Did the device have a sharps injury prevention feature, i.e., a "safety device"?

☐ Yes ☐ No ☐ Unknown/Unable to determine

If yes, when did the injury occur?

☐ Before activation of safety feature was appropriate
☐ Safety feature failed after activation
☐ During activation of the safety feature
☐ Safety feature not activated
☐ Safety feature improperly activated
☐ Other: _____

Describe what happened with the safety feature, e.g., why it failed or why it was not activated:

_____

Section III. Narrative

Describe how the exposure occurred and how it might have been prevented:_____

Section IV. Exposure and Source Information

A. Exposure Details: *(Check all that apply.)*

1. Type of fluid or material (For body fluid exposures only, check which fluid in adjacent box.)

- ☐ Blood/blood products
- ☐ Visibly bloody body fluid*
- ☐ Non-visibly bloody body fluid*
- ☐ Visibly bloody solution (e.g., water used to clean a blood spill)

***Identify which body fluid**

___ Cerebrospinal	___ Urine	___ Synovial
___ Amniotic	___ Sputum	___ Peritoneal
___ Pericardial	___ Saliva	___ Semen/vaginal
___ Pleural	___ Feces/stool	___ Other/Unknown

2. Body site of exposure. *(Check all that apply.)*

☐ Hand/finger ☐ Eye ☐ Mouth/nose ☐ Face

☐ Arm ☐ Leg ☐ Other (Describe: _____)

3. If percutaneous exposure:

Depth of injury *(Check only one.)*

- ☐ Superficial (e.g., scratch, no or little blood)
- ☐ Moderate (e.g., penetrated through skin, wound bled)
- ☐ Deep (e.g., intramuscular penetration)
- ☐ Unsure/Unknown

Was blood visible on device before exposure? ☐ Yes ☐ No ☐ Unsure/Unknown

4. If mucous membrane or skin exposure: *(Check only one.)*

Approximate volume of material

- ☐ Small (e.g., few drops)
- ☐ Large (e.g., major blood splash)

If skin exposure, was skin intact? ☐ Yes ☐ No ☐ Unsure/Unknown

B. Source Information

1. Was the source individual identified? ☐ Yes ☐ No ☐ Unsure/Unknown

If YES ID#:_____

2. If known, when was the serostatus of the source determined?

☐ Known at the time of exposure

☐ Determined through testing at the time of or soon after the exposure

3.Attach serostatus of the source patient.

	Obtained
HIV Antibody	☐
HCV Antibody	☐
HbsAg	☐

Section V. Percutaneous Injury Circumstances

A. What device or item caused the injury?

Hollow-bore needle

☐ Hypodermic needle

__ Attached to syringe __ Attached to IV tubing
__ Unattached

☐ Prefilled cartridge syringe needle

☐ Winged steel needle (i.e., butterfly^{R} type devices)

__ Attached to syringe, tube holder, or IV tubing
__ Unattached

☐ IV stylet Phlebotomy

☐ needle Spinal or epidural

☐ needle Bone marrow

☐ needle Biopsy needle

☐ Huber needle

☐ Other type of hollow-bore needle (type: _____)

☐ Hollow-bore needle, type unknown

Suture needle

☐ Suture needle

Glass

☐ Capillary tube

☐ Pipette (glass)

☐ Slide

☐ Specimen/test/vacuum

☐ Other: _____

Other sharp objects

- [ ] Bone chip/chipped tooth
- [ ] Bone cutter
- [ ] Bovie electrocautery device
- [ ] Bur Explorer
- [ ] Extraction forceps
- [ ] Elevator
- [ ] Histology cutting blade
- [ ] Lancet
- [ ] Pin
- [ ] Razor
- [ ] Retractor
- [ ] Rod (orthopaedic applications)
- [ ] Root canal file
- [ ] Scaler/curette
- [ ] Scalpel blade
- [ ] Scissors
- [ ] Tenaculum
- [ ] Trocar
- [ ] Wire
- [ ] Other type of sharp object
- [ ] Sharp object, type unknown

Other device or item

- [ ] Other: _____

B. Purpose or procedure for which sharp item was used or intended.

(Check <u>one procedure</u> type and complete information in corresponding box as applicable.)

- ☐ Establish intravenous or arterial access (Indicate type of line.) →
- ☐ Access established intravenous or arterial line (Indicate type of line <u>and</u> reason for line access.) →
- ☐ Injection through skin or mucous membrane (Indicate type of injection.) →
- ☐ Obtain blood specimen (through skin) (Indicate method of specimen collection.) →
- ☐ Other specimen collection
- ☐ Suturing
- ☐ Cutting
- ☐ Other procedure
- ☐ Unknown

Type of Line

___ Peripheral ___ Arterial
___ Central ___ Other

Reason for Access

___ Connect IV infusion/piggyback
___ Flush with heparin/saline
___ Obtain blood specimen
___ Inject medication
___ Other:_____

Type of Injection

___ IM injection ___ Epidural/spinal anesthesia
___ Skin test placement ___ Other injection
___ Other ID/SQ injection

Type of Blood Sampling

___ Venipuncture ___ Umbilical vessel
___ Arterial puncture ___ Finger/heelstick
___ Dialysis/AV fistula site ___ Other blood sampling

C. When and how did the injury occur? (From the left hand side of page, select the point during or after use that most closely represents when the injury occurred. In the corresponding right hand box, select *one or two* circumstances that reflect how the injury happened.)

☐ During use of the item →

Select one or two choices:

___ Patient moved and jarred device
___ While inserting needle/sharp
___ While manipulating needle/sharp
___ While withdrawing needle/sharp
___ Passing or receiving equipment
___ Suturing
___ Tying sutures
___ Manipulating suture needle in holder
___ Incising
___ Palpating/Exploring
___ Collided with co-worker or other during procedure
___ Collided with sharp during procedure
___ Sharp object dropped during procedure

☐ After use, before disposal of item →

Select one or two choices:

___ Handling equipment on a tray or stand
___ Transferring specimen into specimen container
___ Processing specimens
X Passing or transferring equipment
___ Recapping (missed or pierced cap)
___ Cap fell off after recapping
___ Disassembling device or equipment
___ Decontamination/processing of used equipment
___ During clean-up
___ In transit to disposal
___ Opening/breaking glass containers
___ Collided with co-worker/other person
___ Collided with sharp after procedure
___ Sharp object dropped after procedure
___ Struck by detached IV line needle

☐ During or after disposal of item →

Select one or two choices:

___ Placing sharp in container:
__ Injured by sharp being disposed
__ Injured by sharp already in container
___ While manipulating container
___ Over-filled sharps container
___ Punctured sharps container
___ Sharp protruding from open container
___ Sharp in unusual location:
__ In trash
__ In linen/laundry
__ Left on table/tray
__ Left in bed/mattress
__ On floor
__ In pocket/clothing
__ Other unusual location
___ Collided with co-worker or other person
___ Collided with sharp
___ Sharp object dropped
___ Struck by detached IV line needle

☐ Other (Describe): _____

_____

_____

_____

☐ Unknown

Section VI. Mucous Membrane Exposures Circumstances

A. What barriers were used by worker at the time of the exposure? *(Check all that apply.)*

☐ Gloves Single ☐ Goggles ☐ Eyeglasses ☐ Face Shield ☐ Mask ☐ Gown

☐ Gloves double ☐ Other barriers in use _____

B. Activity/Event when exposure occurred *(Check one.)*

- ☐ Patient spit/coughed/vomited
- ☐ Airway manipulation (e.g., suctioning airway, inducing sputum)
- ☐ Endoscopic procedure
- ☐ Dental procedure
- ☐ Tube placement/removal/manipulation (e.g., chest, endotracheal, NG, rectal, urine catheter)
- ☐ Phlebotomy
- ☐ IV or arterial line insertion/removal/manipulation
- ☐ Irrigation procedure
- ☐ Vaginal delivery
- ☐ Surgical procedure (e.g., all surgical procedures including C-section)
- ☐ Bleeding vessel
- ☐ Changing dressing/wound care
- ☐ Manipulating blood tube/bottle/specimen container
- ☐ Cleaning/transporting contaminated equipment
- ☐ Other:
- ☐ Unknown

Comments: _____

Record Keeping Requirements for Sharps Injuries

The OSHA 300 Log

Group sharps injuries in with all other work-related injuries. Is a different document with different requirements than the Needlestick Injury Log.

A work related sharps injury is recordable on the OSHA 300 log if:

- ❑ It causes a death
- ❑ It causes an illness
- ❑ It involves an injury which requires medical treatment beyond first aid (even if treatment is offered and refused).
- ❑ Sharps injury = exposure

First Aid	Medical Treatment (recordable)
❑ **Antiseptics during first visit**	❑ **Treatment of infection**
❑ **Application of bandage**	❑ **Application of antiseptics at 2nd and 3rd visits**
❑ **Use of non-prescription medications**	❑ **Administration of >1 dose of prescription medication**
❑ **Single dose of prescription medication**	❑ **Administration of hepatitis vaccination**
❑ **Administration of tetanus shot or booster**	❑ **Lab test or x-ray that shows injury or infection**
❑ **Lab test or x-ray that shows no injury or infection from that injury**	

The Sharps Injury Log **(States may have additional requirements)**

All contaminated sharps injuries must be recorded. Non-sharp related exposures are not recorded here.

- ❑ **The report has names**
- ❑ **Department where exposure incident occurred**
- ❑ **How the incident occurred**
- ❑ **Type and brand of sharp involved in the exposure incident**

This information may be recorded on a separate document or may be included in the data you collect following an exposure investigation. It is acceptable to maintain the information in computer files if you are able to sort the report for sharps injuries only and access it in a timely manner for OSHA if requested

Sharps Injury Log

Date	Employee *Name*	Device Used	Task Performed	Location of the Incident

Declination Form

Post – Exposure Medical Treatment

I understand that due to my occupational exposure I may be at risk for acquiring - _____ disease. I have been given the opportunity to be treated prophylatically for this exposure, at no charge to myself. However, I decline follow up medical treatment at this time. I understand that by declining this treatment, I continue to be at risk for acquiring the disease to which I have been exposed. I understand that if I acquire this disease I will be placed under the Departments work restriction guidelines.

Name_____ Date: _____

Signature_____

Physician Counseling Documentation Form

This form is to serve as documentation that _____ an employee of_____. Has been advised of the results of laboratory testing that was performed on_____. This laboratory work was performed for the purpose of:

_____Post exposure medical follow up

_____ Annual physical exam

_____ Post hiring physical examination

Appropriate counseling was provided to this employee and all test results will remain confidential. A copy of the results will be held in the employee's confidential medical record.

_____ _____

Physician Signature Employee Signature

Date: _____

PROVIDENT

Insuring America's Heroes Since 1928

FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
272 ALPHA DRIVE - P.O. BOX 11588
PITTSBURGH, PA 15238
TOLL-FREE: 800-447-0360
PHONE: 412-963-1200
CLAIMS DEPT FAX: 412-963-0148
www.providentbenefits.com

Name			Date of Birth / /	Social Security Number
Address	City	State Zip Code		Home Phone Number ( )
What is your regular occupation?			Employed By (Name of Company)	
Employer's Address	City	State Zip Code		Employer's Phone Number ( )
Please enclose pay stubs or prior year Schedule Cs (self employed).		Wages/Earnings Hourly: Weekly:		Date Last Worked / /
Time of Accident ☐ AM ☐ PM	Date of Accident / /		Place of Accident	
What is your injury or illness?		How did it happen?		
Name and Address of Treating Physician			Name and Address of Hospital	
Did you lose any Time from Work? ☐ Yes ☐ No ☐ Unknown at this time			Did you file with Workers' Compensation? ☐ Yes ☐ No	
I was totally disabled from / / to / /				
I was partially disabled from / / to / /				
Date you have or are expected to return to work / /				

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Accident Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant Signature _____

THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY.

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

☐ Yes ☐ No – Claimant was a member of your organization at the time of injury or illness ☐ Yes ☐ No – Claimant was engaged in an authorized activity at the time of injury or illness			Policy Number
Name of Fire/Rescue/Ambulance Company/District or Relief Association			Your Municipality
Print Name and Title		Signed	Date / /
Address City	State	Zip Code	Telephone Number ( )

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Underwritten by Provident Life and Accident Insurance Company
1 Fountain Square, Chattanooga, TN 37402

Provident Agency, Inc.; 272 Alpha Drive; P.O. Box 11588
Pittsburgh, PA 15238
Phone: 800-447-0360 Fax: 412-963-0148

NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for Unum Group, its insurance subsidiaries* and duly authorized representatives ("Unum"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits, which may include assisting me in returning to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____

(Claimant Signature) (Date Signed)

_____ _____

(Print Name) (Social Security Number)

I signed on behalf of the claimant as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America and Provident Life and Accident Insurance Company.

ACORD® WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER / ADMINISTRATOR CLAIM NUMBER *	REPORT PURPOSE CODE *
	JURISDICTION * / JURISDICTION LOG NUMBER *	
	INSURED REPORT NUMBER / OSHA CASE NUMBER	
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #: / PHONE #
INDUSTRY CODE / EMPLOYER FEIN		

CARRIER / CLAIMS ADMINISTRATOR

CARRIER (NAME AND ADDRESS)	POLICY PERIOD TO / CHECK IF APPROPRIATE	CLAIMS ADMINISTRATOR (NAME AND ADDRESS)
PHONE (A/C, No, Ext):	☐ SELF INSURANCE	PHONE (A/C, No, Ext):
CARRIER FEIN * / POLICY / SELF-INSURED NUMBER		ADMINISTRATOR FEIN *
AGENT NAME:	AGENT CODE NUMBER:	

EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS: ☐ UNMARRIED/SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION / JOB TITLE	
E-MAIL ADDRESS:			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE *	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED / WEEK	FULL PAY FOR DAY OF INJURY? (Y / N) ☐ / DID SALARY CONTINUE? (Y / N) ☐

OCCURRENCE / TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE ☐ CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME / PHONE (A/C, No, Ext):		TYPE OF INJURY / ILLNESS		PART OF BODY AFFECTED	
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? (Y / N) ☐		TYPE OF INJURY / ILLNESS CODE *		PART OF BODY AFFECTED CODE *	
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL			CAUSE OF INJURY CODE *		
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? (Y / N) ☐ / WERE THEY USED? (Y / N) ☐			
PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT: ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC / HOSP ☐ EMERGENCY CARE ☐ OVERNIGHT HOSPITALIZATION ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		
WITNESS NAME: / PHONE (A/C, No, Ext):		WITNESS NAME: / PHONE (A/C, No, Ext):			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER	

IAIABC 1A-1 (1/1/02)
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APPLICABLE IN ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

APPLICABLE IN ALASKA

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

APPLICABLE IN ARIZONA

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN ARKANSAS

Any person or entity who willfully and knowingly makes any material false statement or representation or who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme or artifice for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

APPLICABLE IN CALIFORNIA

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

APPLICABLE IN COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN CONNECTICUT

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

APPLICABLE IN DELAWARE AND OKLAHOMA

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulations: Del #C Section 913(B)

APPLICABLE IN THE DISTRICT OF COLUMBIA

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA

Pursuant to S. 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in S. 775.082, S. 775.083, or S. 775.084, Florida Statutes.

APPLICABLE IN HAWAII

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

EMPLOYEE SIGNATURE: _____

APPLICABLE IN IDAHO

Any person who knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

APPLICABLE IN INDIANA

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

APPLICABLE IN KANSAS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KENTUCKY, LOUISIANA, MAINE, MICHIGAN, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH DAKOTA, PENNSYLVANIA, RHODE ISLAND, SOUTH DAKOTA, VIRGINIA AND WEST VIRGINIA

Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and [NY: substantial] civil penalties. In LA, ME and VA, insurance benefits may also be denied.

APPLICABLE IN MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MINNESOTA

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEVADA

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

APPLICABLE IN NEW HAMPSHIRE

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

APPLICABLE IN OHIO

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICABLE IN TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

APPLICABLE IN TEXAS

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN UTAH

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

EMPLOYEE SIGNATURE: _____

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN FIELDS MARKED *

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System published by the Federal Office of Management and Budget.

OSHA CASE NUMBER:

Transfer the case number from the OSHA 300 log after you record the case there.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION / JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise deigned by statute.

CONTACT NAME / PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY / ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness / abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following the most recent disability period on which the employee returned to work.