Medical Incident Form

IMMEDIATE ACTION: Please take any steps necessary to treat your current medical condition. Once stable, please contact Insight via phone (856) 406-6015 to report and fax this form to (856) 994-1009. Please use a separate piece of paper if more room is needed.

Employee Name: _____ DOB_____

Address: _____ City: _____ State: ____ Zip:_____

Phone (cell): _____ Home: _____

Date of Hire: _____ Marital Status: _____ # of Dependents: _____

Social Security Number _____Estimated number of shifts you work a week: ____

Please describe the medical incident and the immediate care plan:

_____

_____

_____

_____

What date/time did the incident occur: _____ Where: _____

Did you go somewhere to seek medical treatment: _____(Yes ___/__No)_____

Please provide the name/phone of the Medical Center you went to:

_____

Were there any witnesses besides children?

Who: _____ their phone #: _____

Who: _____ their phone #: _____

Signature: _____ Date: _____