Incident Report

Name of injured	SS No. (last 4)	Date of Birth	Job Title

Rig #	How long employed	Incident date	Incident time	Time in present occupation	Supervisor

Incident Summary:

_____

_____

_____

Describe injury/part(s) of body affected.

What machine/tool/object caused the injury?

Exact location of incident.

Was employee working alone or with other employees at time of incident?

Was employee familiar with the job? Yes__ No ___

Was employee using proper safety equipment? Yes ___ No _____

Other conditions at time of incident. (rain, ice, snow, wind, hot, cold)

Hours worked on tour prior to injury.

Number of consecutive days worked prior to injury.

Had employee worked extra hours within 3 days prior to incident. Yes _____ No _____

Was the incident reviewed with the Toolpusher and management? Yes ____ No. _____

Was a JSA performed prior to starting the job? Yes ____ No. _____

Incident Type (check all that apply)

☐ First Aid	☐ Non-company property damage
☐ Medical Treatment Only	☐ Fire
☐ OSHA Recordable (no lost time)	☐ Spill
☐ OSHA Recordable (restricted duty)	☐ Unsafe act
☐ OSHA Recordable (lost workday)	☐ Unsafe condition
☐ Vehicle damage	☐ Environmental issue
☐ Property damage	☐ Other
☐ Non-company vehicle damage	

Incident Category (check all that apply)

☐ Material handling	☐ Caught between
☐ Tool handling or use	☐ Chemical related
☐ Slip, trip, fall	☐ Particle in eye
☐ Sharp object	☐ Struck against
☐ Thermal burn	☐ Equipment failure
☐ Struck by	☐ Other

INCIDENT SEQUENCE: (Describe in order the sequence of events. Attach additional pages if needed.)

ANALYSIS OF INCIDENT AND CONTRIBUTING FACTORS: Attach additional pages if needed).

PROCEDURE: (is there a procedure for the task being performed at the time of the incident? Yes ___No_____ If yes, should the procedure be modified, and if so, how should it be modified.

FACTUAL ANALYSIS AND DETERMINATION OF ROOT CAUSE(S):

RECOMMENDATIONS AND ACTION DATES: (Actions to be taken for equipment, conditions, training, protective equipment, etc.).

Personnel –

Mechanical –

Procedural –

_____ _____

Signature of Investigator Date

(By signing here I signify that the statements made herein are true and accurate to the best of my ability and belief.)

WITNESS OF INCIDENT REPORT

Injured Employee: _____ **Date of incident:** _____

Statement of: _____ **Date of Statement:** _____
(please print last, first, middle)

Your job title at time of incident: _____

Did you witness this incident: _____Yes _____ No

Please describe how this incident occurred as you saw it. _____

_____

_____

_____

_____

Other comments: _____

_____

_____

Suggestions on how to prevent reoccurrence: _____

_____

_____

_____

Signed: _____ **Date:** _____

Witnessed by: _____ **Date:** _____

REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Name: _____ Date Reported: _____

Date of Injury: _____ Time of Injury: _____

Supervisor: _____ Client / Location: _____

Witness(es): _____

Nature of Injury/Condition:

_____

Description of Injury [Body Part(s) Injured]:

_____

Brief Narrative Description of the Incident:

_____

_____

_____

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of McVay Drilling Company for the work-related injury I incurred on _____.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time, that my employer, will not be responsible for any medical expenses or lost wages.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above described injury.

_____ _____

Employee's Signature Date

_____

Company Representative

All portions of this form *must* be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPPA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name				Date of Birth	Medical Records Number
Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information				
Address	City	State	Zip	Telephone Number

Agency or Individual(s) Authorized to Receive my Health Information

McVay Drilling Co. **PO Box 2450** **Hobbs, NM 88241** **575-397-3311**
Axiom Medical Consulting **4840 Panther Creek Drive** **The Woodlands, TX 77381** **281-465-7100**

Health Information that may be used/disclosed is limited to the following:

☐ Progress Notes	☐ History and Physical	☐ Lab	Other: (specify) _____
☐ Emergency Room Record	☐ Imaging/X-Ray Films	☐ Fetal Monitor Strips	_____
☐ Discharge Summary	☐ Consultation(s)	☐ Pathology Report	_____
☐ Operative Note(s)	☐ X-Ray Reports	**X** Entire Record _____(Initial)	_____

Health Information that may be used/disclosed is limited to the following periods of healthcare:

From (date):	To (date):	Account Number:
From (date):	To (date):	Account Number:

Health Information to be released to the above named agency/individual is to be used for the following purpose(s):

☐ At Request of Patient	☐ Research ☐ Billing or Claims Payment	☐ Marketing	Other: (specify) _____ _____
X Treatment/Consultation _____ (Initial)		**X** At Request of Employer _____ (Initial)	

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.
I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.
_____ (Initial) **X** Yes __ No - If applicable, I agree to the release of my medical or billing records containing the sensitive information listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.
This authorization will automatically expire 60 days after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPPA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OF INDIVIDUAL: This information is to be treated in accordance with (HIPPA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*			**Date**	**Time**
Relationship to Patient/Authority to Act on Patient's Behalf			Interpreter, if utilized	
Witness's Signature	Date	Time	Expiration Date or Event	

* Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.