

GUIDELINES FOR REPORTING WORK RELATED INCIDENTS

**Human Resources Department**  
**Attention: Workers' Compensation**  
**111 North Road**  
**Brentwood, NH 03833**

**603-679-9337 phone \*\*\* 679-9357 fax \*\*\* [lfioravante@co.rockingham.nh.us](mailto:lfioravante@co.rockingham.nh.us)**

**ALL INCIDENT REPORTS OR CONCERNS OF WORK RELATED**  
**INCIDENTS SHOULD BE SENT DIRECTLY TO THE HUMAN RESOURCES DEPARTMENT;**  
**ATTENTION WORKERS' COMPENSATION AS SOON**  
**AS POSSIBLE**

All physicians' notes and physicians' return to work releases should be forwarded to the Human Resources Department; Attention Workers' Compensation immediately to facilitate a return to work.

**Department Heads and or Supervisors - When an employee alerts you of a work related injury**

- Have the employee complete Employee Incident Report and to make certain the Accident Investigation Form is completed.
- Supervisor to notify Lisa Fioravante (Human Resources) and incident report should be forwarded to Human Resources Department; Attention Workers' Compensation.
- Employee to be given choice of Occupational Health or Outside Medical Treatment.
- Incident Report brought over to the Human Resources Department and/or be left at:

**HUMAN RESOURCE BOX AT SWITCHBOARD**

**Employee Responsibilities:**

- Notify your Supervisor **IMMEDIATELY** when you have been injured.
- Complete an Incident Report (reports available in every department)
- Employee MUST keep Supervisor/Employer informed and updated regarding medical treatments and progress.

Fill out Incident Report and return to Supervisor immediately. Supervisor will fax to Human Resources Department; Attention Workers' Compensation at 679-9357 or place in box at Switchboard/Reception at the Main Lobby Area of the Nursing Home.

## ROCKINGHAM COUNTY EMPLOYEE INCIDENT REPORT

**\*All information is necessary in order to process claim**

Name _____	Social Security # _____	DOB _____	Tele _____
Address _____		City/Town/State _____	Zip _____
Dept: _____	Position _____	Hourly wage _____	Date of Hire _____
Full/part time _____	Number of hours worked weekly _____		

Telephone 603-679-9337	RETURN COMPLETED FORM TO Human Resources Department – Attention: Workers’ Compensation 111 North Road Brentwood, NH 03833	Fax: 603- 679-9357
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Date of Incident _____	Time _____	AM/PM _____	Exact Location _____
Full description of Incident/ Include any Equipment Involved:			

Part of Body Injured:	■ Witness(s)	■ Date	■ Employee Signature
	■	■	■

<b>TO BE COMPLETED BY SUPERVISOR:</b>	
Employee sent home: Yes ___ No ___	Employee continued working Yes ___ No ___
Supervisor notified Lisa Fioravante; Human Resources Department Yes ___ No ___	
Sent to Emergency Room: Yes ___ No ___	
First Aid Only: Yes ___ No ___	

Comments:
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<b>Supervisor’s Signature</b>	<b>Date:</b>
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