Los Alamos
Los Alamos National Laboratory
Los Alamos, New Mexico 87545

MEDICAL ILLNESS AND INJURY REPORT

Occupational Medicine Group (ESH-2)
667-7890 D421

Date:	
Time In:	

EMPLOYEE INFORMATION

NAME:				Z NO.:
GROUP:	MS:	WORK PHONE:	DATE OF BIRTH:	❒ MALE ❒ FEMALE
OCCUPATION:				EMPLOYER:
HOME ADDRESS:				HOME PHONE:
SUPERVISOR NAME:				PHONE:
SUPERVISOR'S MS:	SUPERVISOR NOTIFIED: ❒YES ❒NO DATE:_____			

ACCIDENT/INCIDENT HISTORY

DATE OF ACCIDENT/INCIDENT	TIME	AREA	BLDG	ROOM
DESCRIPTION OF EVENT:				
WITNESS(ES):				
EMPLOYEE SIGNATURE:			SUPERVISOR SIGNATURE:	

ADMISSION HISTORY DATA

ALLERGIES:	LNMP:	PRESENTING HISTORY/COMPLAINT:
	LAST TETANUS:	
CURRENT MEDS:	T BP	
	P R	
		PMD: / Interviewer's Signature:

MEDICAL EVALUATION

TIME:	CHIEF COMPLAINT:		TESTS/TREATMENTS
			X-RAY:
SUBJECTIVE:			LAB:
			ECG:
			OTHER:
OBJECTIVE:			
			MEDS:
ASSESSMENT:		ICD - 9	
PLAN:			
		RECHECK	
		Date:	
		Time:	❒ SEE EXT. CARE SHEET