Date Submitted: Time Submitted:

Name of Supervisor:

**SECTION 1: GENERAL INFORMATION** (Please Print)

Name(s) of Employee(s) Reporting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Classification:

Department:

Date of Occurrence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ 7.5 Hr. Shift ❑ 11.25 Hr. Shift ❑ \_\_ Hr. Shift

 ❑ Day ❑ Evening ❑ Night

**SECTION 2: DETAILS OF OCCURRENCE/WORKING CONDITIONS**

Provide a brief summary of the occurrence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check one ❑ Is this an isolated incident? ❑ An ongoing problem

\*If there was a shortage of staff at the time of the occurrence, (including support staff), please check one or all of the following that apply:

 ❑ Leaves/Vacation ❑ Sick Call(s) ❑ Vacancies

**SECTION 3: FACTORS CONTRIBUTING TO THE OCCURRENCE**

 Please check off the factor(s) you believe contributed to the workload issue, as applicable:

❑ Change in patient acuity. Provide details:

❑ Number of Admissions \_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Discharges \_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Lack of Equipment/Malfunctioning Equipment/Supplies. Please specify:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Other: (Please specify)

**SECTION 4: REMEDY**

1. At the time the workload issue occurred, did you discuss the issue with your supervisor? ❑ Yes ❑No

 Provide Details:

Was it resolved? ❑ Yes ❑ No

1. Did you discuss the issue with your manager (or designate) on her/his next working day? ❑ Yes ❑ No

 Provide Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was it resolved? ❑ Yes ❑ No

**SECTION 5: RECOMMENDATIONS**

Please check-off one or all the areas you believe should be addressed to prevent similar occurrences:

|  |  |  |  |
| --- | --- | --- | --- |
| ❑ In service  | ❑ Additional training  |   |  |
| ❑ Review staffing/patient ratio | ❑ Review policies/procedures |  |  |
| ❑ Change start/stop times of shift(s). Please specify:  | ❑ Change work routine/quotas  |  |  |
| ❑ Adjust staffing  | ❑ Replace sick calls/vacations time  |  |  |
| ❑ Equipment (Please specify)  |
| ❑ Other:    |

**SECTION 6: EMPLOYEE SIGNATURES**

I/We do not believe the response adequately addresses our concerns.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Submitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return Workload Form to a member of your Executive**

scb491

November 2016