

WORKPLACE INCIDENT REPORT

Check Box: INJURY ILLNESS NEAR MISS

A. EMPLOYEE INFORMATION: ALL FIELDS REQUIRED

EMPLOYEE'S NAME			M/F	DOB	COMPLETE SSN	JOB TITLE/CLASSIFICATION	
EMPLOYEE ID NUMBER	FT <input type="checkbox"/>	Temp <input type="checkbox"/>	Seasonal <input type="checkbox"/>	DATE OF INCIDENT	DATE OF HIRE	TIME WORK DAY BEGAN	TIME OF INCIDENT (AM / PM)
AGENCY #	DEPT	OVERTIME? Y <input type="checkbox"/> N <input type="checkbox"/>	SHIFT? 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	HAS EMPLOYEE LOST TIME FROM WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what date?	
AVERAGE WEEKLY WAGE	AT THE TIME OF THE INCIDENT THE EMPLOYEE WAS: <input type="checkbox"/> on break <input type="checkbox"/> on lunch <input type="checkbox"/> arriving/leaving work for the day <input type="checkbox"/> performing the following task or tasks:						
EMPLOYEE'S HOME ADDRESS				EMPLOYEE'S PHONE # Home & Cell & EMAIL		SUPERVISOR'S NAME, PHONE # & EMAIL	

B. INCIDENT DETAILS: Is there any reason to question how this incident occurred? Yes No Explain:

LOCATION/ADDRESS (where injury occurred):	DESCRIBE WHAT HAPPENED:

C. WAS MEDICAL TREATMENT REQUIRED? Yes No

1. If yes, what type of treatment and where was it received? 2. Is there a follow up appointment and if so, when is it? 3. Was employee put on restricted duty? 4. Can restricted duty be accomodated?

D. PART OF BODY INVOLVED (be specific: left, right, upper, lower, etc.)

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E. TYPE OF INCIDENT

<input type="checkbox"/> Caught on or in	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Fall-same level	<input type="checkbox"/> Bitten
<input type="checkbox"/> Overexertion	<input type="checkbox"/> Electrical	<input type="checkbox"/> Chemical – skin	<input type="checkbox"/> Fall-different level	<input type="checkbox"/> Lifting
<input type="checkbox"/> Struck by/against	<input type="checkbox"/> Slip or Trip	<input type="checkbox"/> Explosion	<input type="checkbox"/> Heat/Cold exposure	<input type="checkbox"/> Cut
<input type="checkbox"/> Auto accident	<input type="checkbox"/> Cumulative injury	<input type="checkbox"/> Puncture	<input type="checkbox"/> Other	

F. WITNESS TO INJURY (attach witness statement to investigation page 2)

NAME #1:	PHONE #	NAME #2:	PHONE #

G. FORM COMPLETED BY:

Print Name & Title	Phone # & Email Address	Date & Time Injury Reported to Agency
		a.m./p.m.
		a.m./p.m.

H. SUPERVISOR'S INVESTIGATION OF INCIDENT

WHAT HAPPENED? (Be specific; include heights, weight, repetitions, dimensions, lighting etc.)

I. WHY DID IT HAPPEN?

ROOT CAUSE #1:
 ROOT CAUSE #2:
 ROOT CAUSE #3:

J. WHAT CORRECTIVE ACTION IS BEING TAKEN TO ELIMINATE POTENTIAL FOR FURTHER INJURY OR ILLNESS?

What specifically is being done? How are we addressing root causes, behavior, hazards, training?

K. DISCIPLINARY ACTION TAKEN: YES NO

Describe:

L. FALL FROM DIFFERENT LEVEL INFORMATION:

Height:	Was a ladder involved? Describe:
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M. CAUSE OF INCIDENT – UNSAFE ACT: BY INJURED PERSON -or- BY OTHER PERSON (NAME):

- | | | |
|---|--|--|
| <input type="checkbox"/> Failure to warn or signal | <input type="checkbox"/> Working/reaching moving equipment | <input type="checkbox"/> Overloading equipment or containers |
| <input type="checkbox"/> Making safety devise inoperative | <input type="checkbox"/> Failure to shut off or lockout | <input type="checkbox"/> Wearing unsafe attire, jewelry etc. |
| <input type="checkbox"/> Not observing where walking or driving | <input type="checkbox"/> Moving objects too heavy | <input type="checkbox"/> Disregard instructions |
| <input type="checkbox"/> Operating at unsafe speed | <input type="checkbox"/> Not wearing PPE | <input type="checkbox"/> Horseplay |
| <input type="checkbox"/> Operating without safety device | <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Lack of training |
| <input type="checkbox"/> Taking unsafe position | <input type="checkbox"/> Using unsafe tools or equipment | <input type="checkbox"/> No unsafe act |
| <input type="checkbox"/> Negligence | <input type="checkbox"/> Employee misconduct | <input type="checkbox"/> Other |

N. CAUSE OF INCIDENT – UNSAFE CONDITION

- | | | |
|--|--|---|
| <input type="checkbox"/> Hazardous arrangement | <input type="checkbox"/> Poor Housekeeping | <input type="checkbox"/> Wet/slippery/icy floor or ground |
| <input type="checkbox"/> Insufficient lighting | <input type="checkbox"/> Unsafe design | <input type="checkbox"/> Other |
| <input type="checkbox"/> Insufficient guarding | <input type="checkbox"/> Ergonomic deficiency | <input type="checkbox"/> Other |
| <input type="checkbox"/> Faulty machine or equipment | <input type="checkbox"/> Hazardous work method | <input type="checkbox"/> Other |
| <input type="checkbox"/> Insufficient ventilation | <input type="checkbox"/> Poor air quality | <input type="checkbox"/> Other |

O. CAUSE INFORMATION

YES	NO	
1. <input type="checkbox"/>	<input type="checkbox"/>	Was employee doing his/her regularly assigned job? Explain a "no" answer below.
2. <input type="checkbox"/>	<input type="checkbox"/>	Did you (supervisor) provide proper instruction on how to do the job safely? Explain a "no" answer below.
3. <input type="checkbox"/>	<input type="checkbox"/>	Was employee doing this job as you had instructed? Explain a "no" answer below.
4. <input type="checkbox"/>	<input type="checkbox"/>	Was proper equipment provided? Explain a "no" answer below.
5. <input type="checkbox"/>	<input type="checkbox"/>	Was the employee using the equipment? Using it properly? Explain a "no" answer below.
6. <input type="checkbox"/>	<input type="checkbox"/>	Have you had similar incidents with this or other equipment in you area? Explain a "yes" answer below.

Additional comments from above:

P. SAFETY INVESTIGATION AND FOLLOW-UP

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Was the investigation thorough?
<input type="checkbox"/>	<input type="checkbox"/>	Was corrective action taken?
<input type="checkbox"/>	<input type="checkbox"/>	Did the supervisor make every attempt to help eliminate the unsafe act or hazard?
<input type="checkbox"/>	<input type="checkbox"/>	Did the employee make every attempt to help eliminate the unsafe act of hazard?

Explanation and recommendations:

Q. INVESTIGATION COMPLETED BY:

Print Name & Title	Phone # & Email Address	Date Completed
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