

## Employee's Report of Injury Form

**Instructions:** Employees shall use this form to report all work related injuries, illnesses, or “near miss” events (which could have caused an injury or illness) – *no matter how minor*. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

I am reporting a work related: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of injury/near miss:	Time of injury/near miss:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when?	Supervisor:
Your signature:	Date:

**Supervisor's Accident Investigation Form**

Name of Injured Person \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(Circle one) Male Female

What part of the body was injured? Describe in detail. \_\_\_\_\_

What was the nature of the injury? Describe in detail. \_\_\_\_\_

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using? \_\_\_\_\_

Names of all witnesses:

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

Date of Event \_\_\_\_\_ Time of Event \_\_\_\_\_

Exact location of event: \_\_\_\_\_

What caused the event? \_\_\_\_\_

Were safety regulations in place and used? If not, what was wrong? \_\_\_\_\_

Employee went to doctor/hospital? Doctor's Name \_\_\_\_\_

Hospital Name \_\_\_\_\_

Recommended preventive action to take in the future to prevent reoccurrence.

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

\_\_\_\_\_  
Supervisor Signature

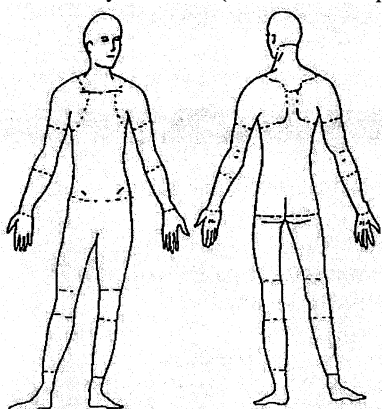
\_\_\_\_\_  
Date

## OPTIONAL - Incident Investigation Report

**Instructions:** The following section is optional. You may complete it in full, partially, or not at all, so long as the previous pages are complete in their entirety. Please fill out this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness.*)

This is a report of a: <input type="checkbox"/> Death <input type="checkbox"/> Lost Time <input type="checkbox"/> Dr. Visit Only <input type="checkbox"/> First Aid Only <input type="checkbox"/> Near Miss	
Date of incident:	This report is made by: <input type="checkbox"/> Employee <input type="checkbox"/> Supervisor <input type="checkbox"/> Team <input type="checkbox"/> Other _____

### Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	
Department:	Job title at time of incident:		
Part of body affected: (shade all that apply)  	Nature of injury: (most serious one) <input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system: <input type="checkbox"/> Other _____	This employee works: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary	
		Months with this employer	
		Months doing this job:	

### Step 2: Describe the incident

Exact location of the incident:	Exact time:
What part of employee's workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other _____	
Names of witnesses (if any):	

<b>Number of attachments:</b>	Written witness statements:	Photographs:	Maps / drawings:
What personal protective equipment was being used (if any)?			
Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.			
Description continued on attached sheets: <input type="checkbox"/>			

<b>Step 3: Why did the incident happen?</b>	
Unsafe workplace conditions: (Check all that apply) <input type="checkbox"/> Inadequate guard <input type="checkbox"/> Unguarded hazard <input type="checkbox"/> Safety device is defective <input type="checkbox"/> Tool or equipment defective <input type="checkbox"/> Workstation layout is hazardous <input type="checkbox"/> Unsafe lighting <input type="checkbox"/> Unsafe ventilation <input type="checkbox"/> Lack of needed personal protective equipment <input type="checkbox"/> Lack of appropriate equipment / tools <input type="checkbox"/> Unsafe clothing <input type="checkbox"/> No training or insufficient training <input type="checkbox"/> Other: _____	Unsafe acts by people: (Check all that apply) <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Servicing equipment that has power to it <input type="checkbox"/> Making a safety device inoperative <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting <input type="checkbox"/> Taking an unsafe position or posture <input type="checkbox"/> Distraction, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment / tools <input type="checkbox"/> Other: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Is there a reward (such as “the job can be done more quickly”, or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If yes, describe:	
Were the unsafe acts or conditions reported prior to the incident? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Have there been similar incidents or near misses prior to this one? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

**Step 4: How can future incidents be prevented?**

**What changes do you suggest to prevent this incident/near miss from happening again?**

- Stop this activity     Guard the hazard     Train the employee(s)     Train the supervisor(s)
- Redesign task steps     Redesign work station     Write a new policy/rule     Enforce existing policy
- Routinely inspect for the hazard     Personal Protective Equipment     Other: \_\_\_\_\_

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets:

**Step 5: Who completed and reviewed this form? (Please Print)**

Written by:	Title:
Department:	Date:
Names of investigation team members:	
Reviewed by:	Title:
	Date: