



Injured Employee Information							
Department:				Location Address:			
Injured Employee:			Job Title:			Employee #:	
D.O.B.:		Date of Injury / Incident:				Time of Incident:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> am <input type="checkbox"/> pm
Employee Work phone:			Work Status:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary... <input type="checkbox"/> Intern <input type="checkbox"/> Volunteer			
Date Reported:			Reported to:			Work Phone:	

Injury / Incident: (Please describe the injury/incident in detail below)

(Check all that apply) Injury Illness Near miss Treated on-site Urgent Care Hospitalized

Name Witnesses:			Work Phone:			Emp. <input type="checkbox"/> Yes <input type="checkbox"/> No
Name Witnesses:			Work Phone:			Emp. <input type="checkbox"/> Yes <input type="checkbox"/> No

Injured Body Part / Type of Injury									
✓	Body Part	R	L	✓	Body Part	R	L	Type of injury: (Check most serious one)	
	Head				Torso			<input type="checkbox"/> Sprain	<input type="checkbox"/> Rash
	Face				Upper Back			<input type="checkbox"/> Strain	<input type="checkbox"/> Overexertion
	Neck				Lowers Back			<input type="checkbox"/> Puncture	<input type="checkbox"/> Dislocation
	Eyes				Hips			<input type="checkbox"/> Crushed	<input type="checkbox"/> Fracture
	Shoulders				Thighs			<input type="checkbox"/> Contusion	<input type="checkbox"/> Amputation
	Upper Arms				Knees			<input type="checkbox"/> Abrasion	<input type="checkbox"/> Whiplash
	Elbows				Lower Legs			<input type="checkbox"/> Burn	<input type="checkbox"/> Other:
	Forearms				Ankles				
	Wrists				Foot/Feet				
	Hands				Toes				
	Fingers				Other:				

Type specific body part →

What was employee doing prior to the incident? What equipment, tools or apparatus were being used?

What personal protective equipment was used (if any)?		
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Nature of injury: (Check most serious one)

- | | | |
|--|---|--|
| <input type="checkbox"/> Struck by | <input type="checkbox"/> Contact with chemical | <input type="checkbox"/> Object being lifted or handled |
| <input type="checkbox"/> Struck against | <input type="checkbox"/> Contact with hot or cold surface | <input type="checkbox"/> Contact with chemical |
| <input type="checkbox"/> Caught in / under / between | <input type="checkbox"/> Repetitive motion | <input type="checkbox"/> Contact with hot or cold surface |
| <input type="checkbox"/> Fall, same level | <input type="checkbox"/> Foreign body in eye or skin | <input type="checkbox"/> Inhalation, ingestion or absorption |
| <input type="checkbox"/> Fall, different level | <input type="checkbox"/> Electrical shock | <input type="checkbox"/> Vehicle accident |
| | | <input type="checkbox"/> Other: |

Unsafe workplace conditions: (Check all that apply)

- Inadequate / unguarded hazard
- Uneven or obstructed walking surface
- Safety device is defective
- Leaving defective tool or equipment in service
- Workstation / area layout is hazardous
- Inadequate lighting
- Inadequate ventilation
- Required personal protective equipment not provided
- Lack of appropriate equipment / tools
- Improper clothing worn
- No training or insufficient training
- Other:

Unsafe acts by people: (Check all that apply)

- Operating without permission
- Operating at unsafe speed
- Servicing equipment that has power to it
- Making a safety device inoperative
- Using defective tool or equipment
- Using tool / equipment in an unapproved way
- Improper lifting or material handling technique
- Taking an awkward position or posture
- Distraction, teasing, horseplay, inattention
- Failure to wear / use required personal protective equipment
- Failure to use the appropriate equipment / tools for job
- Other:

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Why did the unsafe condition(s) exist?

Y N

Why did the unsafe act(s) occur?

Y N

How can future injuries / incidents be prevented?

Corrective Action Taken

Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No	Totals to the right →	Written witness statements: #	Photographs: #	Maps / drawings: #
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Employee Signature

Date

Signature of Dept. Head

Date

Supervisor Signature

Date

Safety Coordinator

Date