

What was the employee doing just before the incident occurred?

Describe the events that led up to the injury. Be specific about the job activity or work process and name any tools or equipment the employee was using when the incident occurred. Examples: "climbing a ladder while carrying roofing materials"; "spraying cleaner from hand sprayer"; "lifting a patient on to a stretcher"; "supervising inmates."

What happened to cause this injury?

Describe the sequence of events including other persons involved, objects, tools, machinery, chemicals, etc. that directly injured the employee or made the employee ill. Examples: "when ladder slipped on wet floor, employee fell 20 feet"; "employee slipped on the wet floor and fell"; "employee was sprayed with chlorine when gasket broke during replacement"; "employee dislocated left shoulder while restraining an inmate".

What object or substance directly harmed the employee?

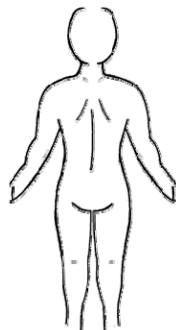
Examples: "concrete floor"; "chlorine", "radial arm saw"; "loaded syringe". *If this question does not apply to the incident, leave it blank.*

Injury/Illness

Part of the body affected (shade in all that apply):



Front



Back

Nature of Injury (check the most serious one)

- Abrasion, scrapes
- Amputation
- Broken bone
- Bruise
- Burn (heat)
- Burn (chemical)
- Concussion (to the head)
- Crushing injury
- Cut, laceration, puncture
- Hernia
- Illness
- Sprain, strain
- Damage to a body system _____
- Other _____

General Description of Injury/Illness

Examples: "Sprained right wrist", "cut 4th finger on left hand", "broken left ankle".

Why did this incident happen?	
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"/> Work area or area 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 on <input type="checkbox"/> Making safety device inoperative or failing to use guard <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, inattention, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use available tools / equipment <input type="checkbox"/> Other _____
Why did the unsafe conditions exist?	Why did the unsafe acts occur?

Medical Care / Treatment			
<input type="checkbox"/> No medical treatment	<input type="checkbox"/> Minor treatment by Employer	<input type="checkbox"/> Minor treatment at PrimeCare	
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Hospitalized > 24 hours		
Date Treatment Received:	Time: AM/PM	Medical Facility Name:	
Address:			Phone:
Name of Treating Physician or Health Care Provider:	Address		Phone:
Transported to medical facility by:		Date returned to work:	

Witnesses					
1	Name:			Phone:	
	Address:		City:	State:	Zip:
	Where was witness at time of occurrence:				
2	Name:			Phone:	
	Address:		City:	State:	Zip:
	Where was witness at time of occurrence:				
3	Name:			Phone:	
	Address:		City:	State:	Zip:
	Where was witness at time of occurrence:				

Training/PPE	
Did the employee receive supervised training for the type of work being performed?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, by whom?	Date of Last Training:
What safeguards and/or personal protective equipment (PPE) is required for this job? Be specific.	
Was PPE in use at the time of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please explain why not:	

Other Factors	
Is there a reward (such as "the job can be done more quickly") that may have encouraged the unsafe acts or conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe	
Were the unsafe acts or conditions reported prior to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, Date Reported:	Reported to:
How can future incidents be prevented?	
What changes do you suggest to prevent this incident/near miss from happening again?	
<input type="checkbox"/> Stop this activity	<input type="checkbox"/> Guard the hazard
<input type="checkbox"/> Train the supervisor	<input type="checkbox"/> Redesign the task steps
<input type="checkbox"/> Write a new policy/rule	<input type="checkbox"/> Enforce existing policy
<input type="checkbox"/> Personal Protective Equipment	<input type="checkbox"/> Other
<input type="checkbox"/> Train the employee(s)	<input type="checkbox"/> Redesign the work area
	<input type="checkbox"/> Routinely inspect for the hazard

Employee's Signature: _____ **Date:** _____

Part II – To be completed by the employee's supervisor

Supervisor's Section – Please be sure that the employee or designee has answered all questions.	
Why did this injury/illness occur?	
What corrective action has been taken or will be taken to eliminate future occurrences?	
Date Correction Action Taken:	Risk Assessment (probability of this event recurring): <input type="checkbox"/> Likely <input type="checkbox"/> Possible <input type="checkbox"/> Unlikely
Severity Potential: <input type="checkbox"/> Major <input type="checkbox"/> Severe <input type="checkbox"/> Minor	Exposure Frequency: <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare

Supervisor's Signature: _____ **Date:** _____