

# INCIDENT REPORT

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

## TO BE COMPLETED BY INJURED EMPLOYEE

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

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

Telephone \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Job classification \_\_\_\_\_

Hourly Wage Rate \_\_\_\_\_ Department Where Injury Occurred \_\_\_\_\_

Where you doing your regular job?  Yes  No Supervisors Name \_\_\_\_\_

Date of Injury \_\_\_\_\_ 20\_\_\_\_ Time \_\_\_\_\_  AM  PM Time Shift Started \_\_\_\_\_  AM  PM

State fully what you were doing at time of injury and how injury occurred: \_\_\_\_\_

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Nature and location of injury (Describe fully exact location of injury, right or left, etc.) \_\_\_\_\_

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Was any other part of body injured?  Yes  No (Describe) \_\_\_\_\_

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Was First-Aid Given?  Yes  No (Describe) \_\_\_\_\_

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Date You Reported Injury \_\_\_\_\_, 20\_\_\_\_ Time \_\_\_\_\_  AM  PM Reported to \_\_\_\_\_

Anyone else injured:  Yes  No (Names) \_\_\_\_\_

Name, Address, Phone # of person observing incident \_\_\_\_\_

Witness to Signature \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY SUPERVISOR**

Was employee performing his regular job?  Yes  No

Was employee properly instructed on safe job procedure?  Yes  No Describe \_\_\_\_\_

When did you first know of injury? Date \_\_\_\_\_, 20\_\_\_\_\_ Time \_\_\_\_\_  AM  PM

<u>CAUSE OF INJURY</u>	<u>PROTECTIVE EQUIPMENT</u>	<u>REQUIRED</u>	<u>IN USE</u>
<input type="checkbox"/> Inattention to duties being performed	Hard Hat	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Insufficient Instructions	Safety Glasses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Improper Instructions	Safety Shoes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Inadequate Job Planning	Dust Goggles	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lack of Knowledge or Skill	Full Face Shield	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Improper Use of Equipment	Respirator	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Inadequate or Wrong Equipment	Hearing Protection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fatigue	Welding Hood	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Disability	Cutting Goggles	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Uncooperative	Other	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	Other	<input type="checkbox"/>	<input type="checkbox"/>

What was defective, in unsafe condition, or wrong with method used? \_\_\_\_\_

What did employee do unsafely? \_\_\_\_\_

What could or should have been done to prevent injury? \_\_\_\_\_

What steps have been or will be taken to prevent similar injuries. \_\_\_\_\_

Was employee instructed to use any special protective equipment or safety procedure?  Yes  No

Describe \_\_\_\_\_

Did employee follow these instructions?  Yes  No Describe \_\_\_\_\_

Was injury the result of failure of the employee to follow instructions or established safety rules?  Yes  No

Explain \_\_\_\_\_

What action has been or will be taken because of this failure? (Describe) \_\_\_\_\_

Supervisor's Comments: \_\_\_\_\_