



## EMPLOYEE REPORT OF INCIDENT / ACCIDENT

Date of report: \_\_\_\_\_

The following person reports an injury sustained in a work-related accident as described below.

Name (Print)		Employee Date of Birth	
Address			
City		State	Zip
1.	Date of injury:		Time of injury: AM PM
2.	Address where injury occurred:		
3.	Description of injury and part of body affected. Please describe below:		
4.	Did you seek medical attention? (please select): <input type="checkbox"/> Yes <input type="checkbox"/> No		
5.	Name of medical facility:	Phone Number	
	Physician	City	
	Address	State/Zip	
6.	Did you treat yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state below what treatment you have done to date: _____		
7.	Did you report this injury to anyone (please select): <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If so to whom:	Date/Time:	
8.	Where there witnesses? (please select) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide information below:		
	<b>Witness 1 Name</b>	Phone	
	Address, City/State/Zip		

	<b>Witness 2 Name</b>		Phone		
	Address, City/State/Zip				
9.	<b>ANALYSIS.</b> Place a check in the appropriate box and detail your findings in the explanation section.				
	Were any unsafe conditions present? If yes, explanation required.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Were all safety rules being followed? If no, explanation required.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Was the equipment in good working condition? If no, explanation required.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Was the employee performing an unsafe act? If yes, explanation required.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Is this the employee's normal job? If no, explanation required.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Was the employee working within the job description? If no, explanation required.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Was the employee following agency policies? If no, explanation required.	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Explanation of analysis findings:				
10.	Report filled out by:		Title:		
	Employee Signature:		Date:		

**Return completed form to Safety Coordinator/Lori Mortensen within 24 hours of incident**

**For office use only:**

11.	Was the employee referred to seek medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, describe referral process and follow up if needed: _____ _____ _____ _____
12.	Based on the causes listed above, indicate what corrective actions will be taken to prevent a recurrence of this type of accident: _____ _____ _____ _____