

## 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

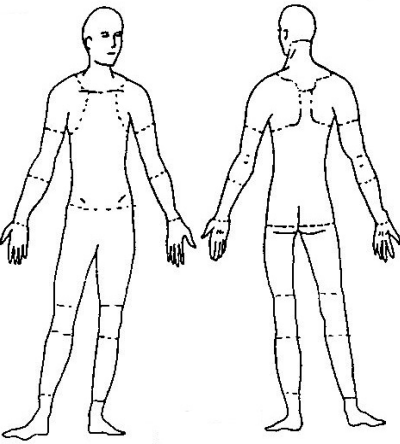
\_\_\_\_\_  
Date

# Incident Investigation Report

**Instructions:** Complete 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)	This employee works:
	<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 _____	<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? <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	
Have there been similar incidents or near misses prior to this one? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**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: