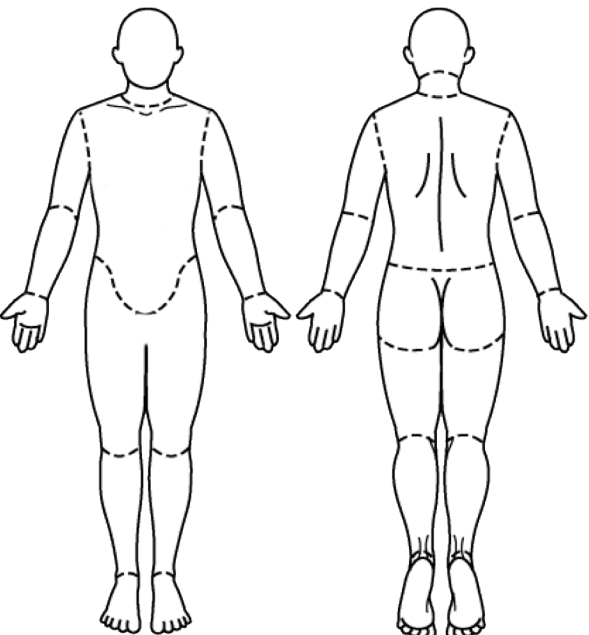


Please complete this form as soon as possible after an incident that results in serious injury or illness occurs. (Optional: Use to investigate a minor injury or near miss that could have resulted in a serious injury or illness.)

This is a report of a:  Death  Lost Time  Dr. Visit Only  First Aid Only  Near Miss

Date of Incident: \_\_\_\_\_

## Step 1: Complete this part for each Injured Employee

Injured Employee Name: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age: _____
Department: _____		Job title at time of incident: _____	
<b>Part of body affected:</b> (shade all that apply)  	<b>Nature of injury:</b> (most serious one) <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: (e.g. nervous, respiratory or circulatory system)  <input type="checkbox"/> Other: _____	<b>This employee works:</b> <input type="checkbox"/> Regular Full-Time <input type="checkbox"/> Regular Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary  <b>Months with this employer:</b> _____  <b>Months doing this job:</b> _____	

## Step 2: Describe the Incident

Address of where the incident occurred: _____		City: _____	State: _____	Zip Code: _____
Exact location of the incident (i.e. specific room): _____		Exact Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<b>What part of employee's workday:</b> <input type="checkbox"/> During meal period	<input type="checkbox"/> Entering or leaving work <input type="checkbox"/> During break	<input type="checkbox"/> Doing normal work activities <input type="checkbox"/> Working overtime	<input type="checkbox"/> Other	
Name of Witness(es) if any: _____				



## Step 4: How can future incidents be prevented?

**What changes:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Stop this activity               | <input type="checkbox"/> Guard the hazard              | <input type="checkbox"/> Train the employee(s)   | <input type="checkbox"/> Train the supervisor(s) |
| <input type="checkbox"/> Redesign task steps              | <input type="checkbox"/> Redesign work station         | <input type="checkbox"/> Write a new policy/rule | <input type="checkbox"/> Enforce existing policy |
| <input type="checkbox"/> Routinely inspect for the hazard | <input type="checkbox"/> Personal Protective Equipment | <input type="checkbox"/> 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)

<b>Written by:</b>	<b>Title:</b>
<b>Department:</b>	<b>Date:</b>

**Names of investigation team members:**

Description continued on attached sheets

<b>Reviewed by:</b>	<b>Title:</b>
	<b>Date:</b>