

ACCIDENT & INJURY REPORTS

WELCOME!

This sample program is provided to assist you as an employer in developing programs tailored to your own operation. We encourage you to copy, expand, modify and customize this sample as necessary to accomplish this goal.

This document is provided as a compliance aid, but does not constitute a legal interpretation of OSHA Standards, nor does it replace the need to be familiar with, and follow, the actual OSHA Standards (including any North Carolina specific changes.) Though this document is intended to be consistent with OSHA Standards, if an area is considered by the reader to be inconsistent, the OSHA standard should be followed. Of course, we welcome your comments and feedback!

Remember: A written safety/health program is only effective if it is put into place!

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.

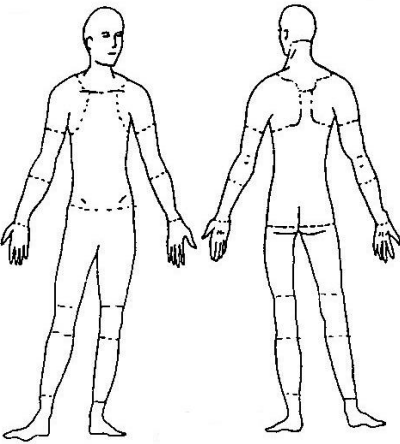
Supervisor Signature

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) <div style="text-align: center;">  </div>	Nature of injury: (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: <input type="checkbox"/> Other _____	This employee works: <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): 	

Number of attachments:	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"/>			

Step 3: Why did the 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"/> 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: