# **INCIDENT REPORT FORM**

* This form to be completed for **all** **job-related injuries or illnesses** – **regardless of extent**.
* Must be completed by supervisor within 24 hours of incident
* SAIF Coordinator must receive notification within 24 hours of **all** incidents.

**IF EMPLOYEE RECEIVES MEDICAL TREATMENT OR MISSES TIME FROM WORK, A WORKERS’ COMPENSATION CLAIM - FORM 801 MUST BE COMPLETED AND SENT TO THE SAIF COORDINATOR WITHIN 24 HOURS.**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Tile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Middle Last

AM AM

Date of Injury: Hour: PM Time Left Work: PM Date of Birth:

|  |  |  |
| --- | --- | --- |
| Department Name | Name of Supervisor | Date Reported to Supervisor |
| Exact Location of Accident: | | Name of Witness: |

Describe Accident (What was injured worker doing; what objects, machines o materials were involved):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |
| --- | --- |
| Regular Days Off | Working Shift AM AM  PM to PM |

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

### **ACTION BODY PART INJURED NATURE OF INJURY**

 FIRST AID CASE ONLY  HEAD  FACE  EYE  ABRASION  LACERATION  PUNCTURE

 REQUIRED DOCTOR’S CARE  NECK  BACK  CHEST  BRUISE  FRACTURE  BURN

 HOSPITALIZED  ARM  HAND  FINGER  SPRAIN/STRAIN  FOREIGN BODY  POISON OAK

 OSHA NOTIFIED  LEG  KNEE  ANKLE  COLD INJURY  HEAT NJURY  DEMATITIS

 TIME LOSS  FOOT  TOE  LOSS OF  OCCUPATIONAL

 NO INJURY/NEAR MISS  OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONCIOUSNESS ILLNESS

 OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### **ADDITIONAL NOTES**

## **SUPERVISOR’S INVESTIGATION OF CAUSE (CHECK ONE OR MORE)**

**If employee admitted to hospital, OSHA must also be contacted within 24 hours. This is a supervisor’s responsibility – Call OSAH at 776-6030.**

Did you personally view the incident site? Yes  No Employee Category  Faculty  Staff  Student

**UNSAFE ACTS UNSAFE CONDITIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| * OPERATING WITHOUT AUTHORITY | * HORSEPLAY | * IMPROPERLY GUARDED EQUIPMENT OR MACHINE | * INADEQUATE WARNING SYSTEM |
| * FAILURE TO WARN OTHERS | * FAILURE TO USE PERSONAL PROTECTIVE DEVICES | * DEFECTIVE TOOL OR EQUIPMENT | * HAZARDOUS STORAGE OR ARRANGEMENT |
| * OPERATING OR WORKING AT UNSAFE SPEED | * FAILURE OT OBSERVE SAFETY REGULATIONS | * POOR HOUSEKEEPING | * HAZARDOUS DRESS OR APPAREL |
| * MAKING SAFETY DEVICES INOPERATIVE | * LACK OF TRAINING OR KNOWLEDGE | * IMPROPER LIGHTING | * HAZARDOUS WORK PROCEDURE |
| * FAILURE TO SECURE OBJECTS | * PREVENTABLE VEHICLE ACCIDENT | * IMPROPER VENTILATION (DUST, FUMES, ETC.) | * HAZARDOUES WEATHER OR ENVIRONMENT |
| * USING UNSAFE EQUIPMENT OR EQUIPMENT UNSAFELY | * SLIPS AND FALLS | * UNSAFE DESIGN OR CONSTRUCTION | * CONTACT WITH POISONOUS PLANTS, INSECTS, TOXIC |
| * UNSAFE LOADING, MIXING, CARRYING | * FAILURE TO LOCK OUT/TAG OUT | * SLIPPERY OR OTHER UNSAFE SURFACE | CHEMICALS, SKIN IRRITANTS,  BITES, ECT. |
| * TAKING UNSAFE POSITION OR POSTURE | * OTHER:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * OTHER:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

* REASONS FOR UNSAFE ACT (Must be completed by Supervisor)

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* REASONS FOR UNSAFE CONDITION (Must be completed by Supervisor)

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* WHAT PRACTICAL CORRECTIVE ACTION WILL BE TAKEN BY SUPERVISION TO PREVENT RECURRENCE? (Must be completed by Supervisor.) Note: The wording “be more careful” is unacceptable, as it does not present a viable solution. If the cause is properly identified, there should be several solutions.

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SUPERVISOR’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MANAGEMENT REVIEW SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CHECK IS SAIF FORM 801 WAS COMPLETED**. (801 MUST BE COMPLETED AND RECEIVED BY THE SAIF**

**COORDINATOR WITHIN 24 HOURS)**

 CHECK IF YOU BELIEVE THIS INJURY **IS NOT WORK CONNECTED** AND REPORT TO YOUR SUPERVISOR.