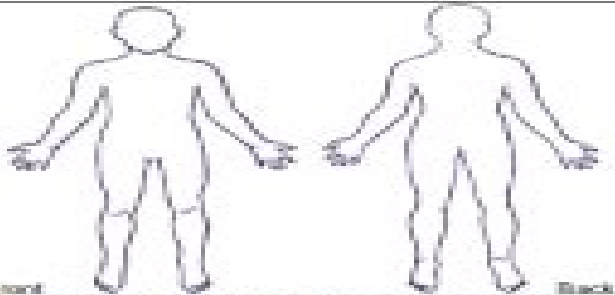


ACCIDENT/INJURY REPORT

This form is to be used to report workplace accidents to include: near misses, injuries, illnesses, or exposures. The person reporting will complete Part I of this report. The supervisor or instructor will conduct a thorough review and complete Part II. The Safety Officer will investigate the event, identify a primary cause, if possible, add any written recommendations and distribute the form when completed.

Do not move equipment involved in a work-related accident involving a death, inpatient hospitalization, amputation, or loss of an eye. The equipment must not be moved until a representative of the Department of Labor and Industries investigates the accident and releases the equipment unless moving the equipment is necessary to: a) Remove any victims or b) Prevent further incidents and injuries.

PART I – COMPLETE WITHIN 24 HOURS					
1. ☐ Employee ☐ Contract staff ☐ Volunteer		3. Sex ☐ M ☐ F ☐ X		4. Birthdate	5. Work phone Ext.
2. Name (Last, First, MI)		7. Normal scheduled shift ☐ Day ☐ Afternoon ☐ Night		8. Days off	
6. Job classification/Working title		10. Address/Mail stop			
9. Assigned work location					
11a. Facility name		11b. Building		11c. General	
12. Incident date		13. Incident time ☐ AM ☐ PM			
14. What part(s) of body was affected (e.g., right ankle, left index finger, lung)?					
15. Type of injury (Check all that apply) ☐ No injury/illness ☐ Dizziness ☐ Blood/Bodily fluids ☐ Ache/Soreness ☐ Disease/Infection ☐ Fumes/Gas/Vapors ☐ Noise ☐ Tingling/Numbness ☐ Wound/Abrasion ☐ Burn-Chemical ☐ Contusion/Brui(e)s ☐ Nausea ☐ Burn-Flame ☐ Contact with toxic/chemicals ☐ Sprain/Strain ☐ Burn-Steam ☐ Needle stick ☐ Other _____					
16. How did you sustain this injury?					
17. What have you done or are going to do to ensure accidents/incidents of this type do not happen in the future?					
18. Did this incident occur during training? ☐ Yes ☐ No			19. Do you believe you were assaulted by an individual under the Department's jurisdiction? (Per DDC 830.180 Assault Benefits for Employees) ☐ Yes ☐ No		
20. Was this a work related injury? ☐ Yes ☐ No			21. Was this an aggravation of a previous injury? ☐ Yes ☐ No		
22. To whom did you report this to?		23. Name of witness, their title, and work telephone number(s)			
Supervisor/instructor name (Last, First, MI)					

Signature _____

Date _____

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