

INJURY/ILLNESS INCIDENT REPORT

Instructions: It is our policy that all work related injuries, illnesses, and "near miss" events be reported no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. You should complete this form directly after the injury/illness or near miss occurs or before the end of the shift.

Please Print

| | | | |
|---|-----------------|---|--|
| Name of injured employee: | | Taken by: | |
| Job title: | | Time/date of report taken: | |
| Supervisor: | | I am reporting a: <input type="checkbox"/> injury <input type="checkbox"/> illness <input type="checkbox"/> near miss | |
| Have you told your supervisor about this accident/near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Work related? <input type="checkbox"/> Yes <input type="checkbox"/> No | Time of injury: | Date of injury: | Shift & department: |
| Names of witnesses (if any): | | First Aid Provided: | Taken to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nature of injury/illness: describe the extent of the injury/illness and specific body parts involved. (use back if needed) | | | |
| What happened? (describe <u>fully</u> . Observe where the accident occurred. What task was being performed?) (use back if needed) | | | |
| If a near miss, how could you have been hurt? | | | |
| Has this part of your body been injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, whom did you see (doctor name & number)? | | | |

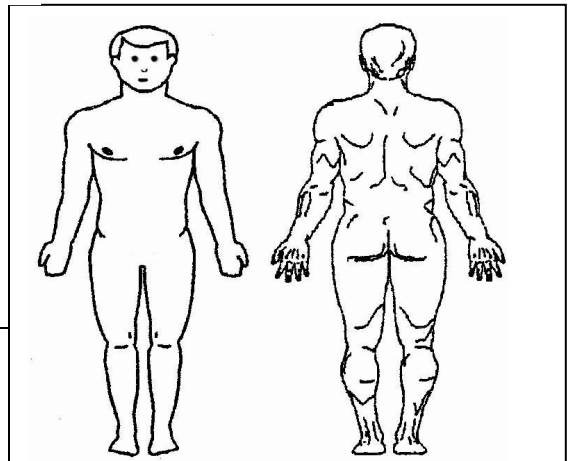
TYPE OF INCIDENT

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Struck Against | <input type="checkbox"/> Slip & Fall | <input type="checkbox"/> Heat | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Struck By | <input type="checkbox"/> Trip over Object | <input type="checkbox"/> Electric / Flash | <input type="checkbox"/> Fall from height |
| <input type="checkbox"/> Caught Between | <input type="checkbox"/> Over Exertion | <input type="checkbox"/> Lifting | <input type="checkbox"/> Chemical Exposure |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Puncture | <input type="checkbox"/> Laceration | <input type="checkbox"/> Other (describe) |

AREA OF INJURY

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Stomach/Abdomen | <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Face | <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Arm (upper) <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Back (general) | <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Ear <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Chest | <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Mouth/Teeth <input type="checkbox"/> U <input type="checkbox"/> L | <input type="checkbox"/> Finger/Thumb <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Groin | <input type="checkbox"/> Toe |
| | (Identify below i.e.: L1, R4, etc.) | | (Identify below i.e.L4, R3.) |

Further Indicate location below by putting an " X " and provide comment:



"The above statements are true and correct. I understand that falsifying this document is grounds for disciplinary action up to and including discharge."

Employee signature: _____ Date: _____