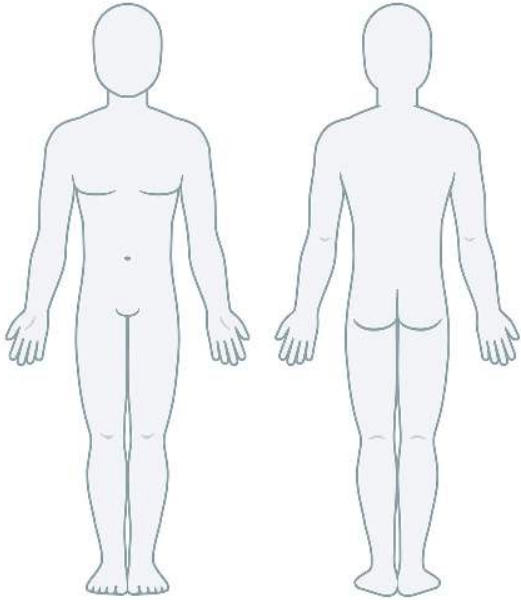


EMPLOYEE INCIDENT/INJURY REPORT

(To be completed by injured employee)

Employee Name		Job Title	
Date of Injury	Time Injury/Incident Occurred		Employee's Start Time
Address Where Injury Occurred	<input type="checkbox"/> Company Address <input type="checkbox"/> Field Location (List address below) <input type="checkbox"/> Other (List address below)		
Employment Status	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Temporary (notify employment agency)
Describe events leading up to incident in detail (<i>what, where, when, how, and why</i>) <input type="checkbox"/> Accident/Injury <input type="checkbox"/> Near Miss			
<hr/> <hr/>			
What object, equipment, movement, or unsafe act or condition directly caused the accident?			
List any witnesses			
Did you seek medical treatment?	Yes / No	Where:	
Indicate / circle body part(s) affected below:		Check factors contributing to incident (all that apply):	
		<input type="checkbox"/> Lack of training/skill	<input type="checkbox"/> Improper guarding
		<input type="checkbox"/> Improper instruction	<input type="checkbox"/> Improper attire
		<input type="checkbox"/> Equipment defective	<input type="checkbox"/> Unsafe position
		<input type="checkbox"/> Unaware of surroundings	<input type="checkbox"/> Poor footing/uneven ground
		<input type="checkbox"/> Not following procedure	<input type="checkbox"/> Unsafe process/arrangement
		<input type="checkbox"/> Distraction/haste	<input type="checkbox"/> Wet floors
		<input type="checkbox"/> Weather related	<input type="checkbox"/> Failure to lock out
		<input type="checkbox"/> Failure to secure	<input type="checkbox"/> Lack of proper PPE
		<input type="checkbox"/> Ergonomic Issue	<input type="checkbox"/> Operating w/o authority
		<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Improper maintenance
		<input type="checkbox"/> Inoperative safety device	<input type="checkbox"/> Tight working area
		<input type="checkbox"/> Poor ventilation	<input type="checkbox"/> Chemical hazard or spill
		<input type="checkbox"/> Electrical hazard	<input type="checkbox"/> Poor lighting
		<input type="checkbox"/> Horseplay	<input type="checkbox"/> Contact with Animal or Insect
<input type="checkbox"/> Improper Tool/Tool Use	<input type="checkbox"/> Other factors (list below)		
Describe injury in detail (use back of page if needed):			
<hr/> <hr/> <hr/>			
Corrective action – what can be done to prevent this from happening again? (use back of page if needed)			
<hr/> <hr/> <hr/>			

I, _____, understand that by signing this report I am submitting a work-related incident described truthfully to the best of my recollection.

Employee Signature: _____

Date: _____

Supervisor's Signature: _____

Date: _____