

# SAMPLE INCIDENT REPORT

For Internal Use

This form must be completed within 24 hours of the Supervisor learning of the incident

<input type="checkbox"/> Injury: <input type="checkbox"/> First Aid <input type="checkbox"/> Medical Aid		<input type="checkbox"/> No Injury	<input type="checkbox"/> Hazardous Situation
<b>THIS SECTION TO BE COMPLETED BY THE EMPLOYEE</b>			
Who was hurt? <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Contractor <input type="checkbox"/> Other	Last name:	First Name:	Phone or Extension:
	Job Title:	Department:	Supervisor:
	Date & Time of Incident:	Date Reported:	Type of Incident: <input type="checkbox"/> Slip*, trip or fall <input type="checkbox"/> Struck by / against object <input type="checkbox"/> Over exertion <input type="checkbox"/> Repetitive strain <input type="checkbox"/> Electrical contact <input type="checkbox"/> Exposure to hazardous material <input type="checkbox"/> Other (describe)
Description of Incident:			
*If this was a SLIP, describe footwear:			
Witnesses to the incident: (names and phone numbers)			
What was the injury (indicate what part of the body):			
Did you see a medical professional? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide name, address and phone number:		Treatment of Injury: <input type="checkbox"/> First Aid <input type="checkbox"/> Walk-in Clinic <input type="checkbox"/> Family Doctor <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other (describe) _____	
<b>THIS SECTION TO BE COMPLETED BY THE SUPERVISOR</b>			
<b>Contributing Factors:</b> What conditions contributed to the incident?			
<input type="checkbox"/> Unsafe equipment	<input type="checkbox"/> Inadequate illumination	<input type="checkbox"/> Not or improperly guarded	<input type="checkbox"/> Hazardous environment
<input type="checkbox"/> Insufficient training	<input type="checkbox"/> Improper position/posture	<input type="checkbox"/> Insufficient care	<input type="checkbox"/> Infraction or unsafe practice
<input type="checkbox"/> Failure to use PPE	<input type="checkbox"/> Operating without authority	<input type="checkbox"/> Failure to lockout	<input type="checkbox"/> Other (Explain)
Explanation of contributing factors:			
Details of property damage (if any):			
To your knowledge, has the employee had a previous similar injury or has this similar hazard been reported before? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
<b>Corrective Measures:</b> Actions taken to prevent a reoccurrence (more than one item may apply):			
<input type="checkbox"/> Request job safety analysis	<input type="checkbox"/> On-the-job training	<input type="checkbox"/> Perform housekeeping	<input type="checkbox"/> Review PPE
<input type="checkbox"/> Improve work procedure	<input type="checkbox"/> Check with manufacturer	<input type="checkbox"/> Re-training of person(s)	<input type="checkbox"/> Constructive Discipline
<input type="checkbox"/> Repair or replace equipment	<input type="checkbox"/> Install safety guard/device	<input type="checkbox"/> Reassignment of person	<input type="checkbox"/> Other (Explain)
Explanation of corrective measures:			
Signature of Employee Reporting Incident:		Date:	Signature of Supervisor:
			Date: