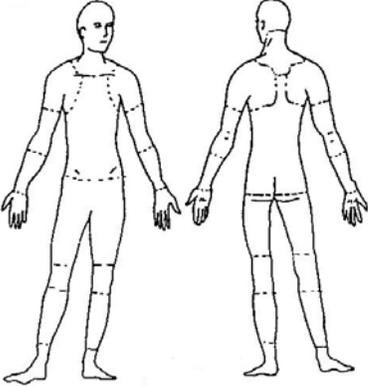




## EMPLOYEE INCIDENT REPORT FORM

- All job-related injuries or illnesses – regardless of extent call 1-877-234-0898 to speak to a nurse 24/7, 365 days a year.
- Report the accident immediately to your supervisor and a physician chosen from the PANEL OF PHYSICIANS must be used if medical treatment is needed.
- If a panel physician is unavailable at the time of an emergency, an emergency facility may treat you; however, any follow up care must be rendered by the physician chosen by you from the Panel of Physicians.
- In addition to calling the nurse hotline above, **this form must be completed by the employee and supervisor and emailed to Michael.Bozeth@winchesterva.gov within 24 hours of all incidents.**

First Name:		Last Name:		Job Title:	
Date of Injury:	Hour:	Time Left Work:		Employee Number:	
	AM PM		AM PM		
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 or materials were involved):					
Regular Days Off:			Working Shift		
			AM PM	to	AM PM
What part of your workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities					
<input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other _____					
		<b>BODY PART INJURED</b>		<b>NATURE OF INJURY</b>	
		<input type="checkbox"/> HEAD <input type="checkbox"/> FACE <input type="checkbox"/> EYE <input type="checkbox"/> NECK <input type="checkbox"/> BACK <input type="checkbox"/> CHEST <input type="checkbox"/> ARM <input type="checkbox"/> HAND <input type="checkbox"/> FINGER <input type="checkbox"/> LEG <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> TOE <input type="checkbox"/> OTHER _____		<input type="checkbox"/> ABRASION <input type="checkbox"/> LACERATION <input type="checkbox"/> PUNCTURE <input type="checkbox"/> BRUISE <input type="checkbox"/> FRACTURE <input type="checkbox"/> BURN <input type="checkbox"/> SPRAIN/STRAIN <input type="checkbox"/> FOREIGN BODY <input type="checkbox"/> POISON <input type="checkbox"/> COLD INJURY <input type="checkbox"/> HEAT INJURY <input type="checkbox"/> DEMATITIS <input type="checkbox"/> LOSS OF CONCIOSNESS <input type="checkbox"/> OCCUPATIONAL ILLNESS <input type="checkbox"/> RESPIRATORY <input type="checkbox"/> OTHER _____	
Please circle part(s) of body affected					

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

Date: \_\_\_\_\_

# SUPERVISOR'S INVESTIGATION OF INCIDENT

## Result of Incident:

- |   |                                       |                                    |
|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> FIRST AID CASE ONLY    | <input type="checkbox"/> HOSPITALIZED | <input type="checkbox"/> TIME LOSS |
| <input type="checkbox"/> REQUIRED DOCTOR'S CARE | <input type="checkbox"/> RECORD ONLY  | <input type="checkbox"/> DEATH     |

Did you personally view the incident site? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employee Category <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Temporary
Names of witnesses (if any):	
Written witness statements/photographs/maps / drawings attached?	
What personal protective equipment was being used (if any)?	
Description continued on attached sheets: <input type="checkbox"/>	

### UNSAFE ACTS

- |   |   |
|---|---|
| <input type="checkbox"/> OPERATING WITHOUT AUTHORITY                  | <input type="checkbox"/> HORSEPLAY                                  |
| <input type="checkbox"/> FAILURE TO WARN OTHERS                       | <input type="checkbox"/> FAILURE TO USE PERSONAL PROTECTIVE DEVICES |
| <input type="checkbox"/> OPERATING OR WORKING AT UNSAFE SPEED         | <input type="checkbox"/> FAILURE TO OBSERVE SAFETY REGULATIONS      |
| <input type="checkbox"/> MAKING SAFETY DEVICES INOPERATIVE            | <input type="checkbox"/> LACK OF TRAINING OR KNOWLEDGE              |
| <input type="checkbox"/> FAILURE TO SECURE OBJECTS                    | <input type="checkbox"/> PREVENTABLE VEHICLE ACCIDENT               |
| <input type="checkbox"/> USING UNSAFE EQUIPMENT OR EQUIPMENT UNSAFELY | <input type="checkbox"/> SLIPS AND FALLS                            |
| <input type="checkbox"/> UNSAFE LOADING, LIFTING, CARRYING            | <input type="checkbox"/> FAILURE TO LOCK OUT/TAG OUT                |
| <input type="checkbox"/> TAKING UNSAFE POSITION OR POSTURE            | <input type="checkbox"/> OTHER: _____                               |

### UNSAFE CONDITIONS

- |   |   |
|---|---|
| <input type="checkbox"/> IMPROPERLY GUARDED EQUIPMENT OR MACHINE  | <input type="checkbox"/> INADEQUATE WARNING SYSTEM  |
| <input type="checkbox"/> DEFECTIVE TOOL OR EQUIPMENT              | <input type="checkbox"/> HAZARDOUS STORAGE OR ARRANGEMENT   |
| <input type="checkbox"/> POOR HOUSEKEEPING                        | <input type="checkbox"/> HAZARDOUS DRESS OR APPAREL   |
| <input type="checkbox"/> IMPROPER LIGHTING                        | <input type="checkbox"/> HAZARDOUS WORK PROCEDURE   |
| <input type="checkbox"/> IMPROPER VENTILATION (DUST, FUMES, ETC.) | <input type="checkbox"/> HAZARDOUS WEATHER OR ENVIRONMENT   |
| <input type="checkbox"/> UNSAFE DESIGN OR CONSTRUCTION            | <input type="checkbox"/> CONTACT WITH POISONOUS PLANTS, INSECTS, TOXIC CHEMICALS, SKIN IRRITANTS, BITES, ECT. |
| <input type="checkbox"/> SLIPPERY OR OTHER UNSAFE SURFACE         | <input type="checkbox"/> OTHER: _____   |

Why did the unsafe conditions exist?
Why did the unsafe acts occur?
Is there is a shortcut (such as "the job can be done more quickly" or "the product is less likely to be damaged" that may have encouraged the unsafe conditions or acts? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:
Were the unsafe acts or conditions reported prior to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have there been similar incidents or near misses prior to this one? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What changes do you suggest to prevent this incident from happening again?</b>
<input type="checkbox"/> Stop this activity <input type="checkbox"/> Guard the hazard <input type="checkbox"/> Train the employee(s) <input type="checkbox"/> Train the supervisor(s) <input type="checkbox"/> Redesign task steps <input type="checkbox"/> Redesign work station <input type="checkbox"/> Write a new policy/rule <input type="checkbox"/> Enforce existing policy <input type="checkbox"/> Routinely inspect for the hazard <input type="checkbox"/> Personal Protective Equipment <input type="checkbox"/> Other: _____
What should be (or has been) done to carry out the suggestion(s) checked above?

IF WARRANTED, WHAT PRACTICAL CORRECTIVE ACTION WILL BE TAKEN BY SUPERVISION TO PREVENT RECURRENCE?

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 \_\_\_\_\_

DEPARTMENT HEAD'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_