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INCIDENT/ACCIDENT REPORT FORM

- Incident analysis helps you in reducing or preventing future occupational injuries and illnesses.
- This form requests all the information that the DWC says you must record for each on-the-job injury, fatality, and occupational disease. Employers must keep injury records for five years after the last day of the year in which the injury occurred.

This is an ☐ Injury ☐ Disease ☐ Fatality ☐ Near-miss

TODAY'S DATE_____ **DATE REPORTED**_____

DEPARTMENT_____ **SUPERVISOR**_____

PHONE NO. _____

TO BE COMPLETED BY SUPERVISOR OR SAFETY MANAGER

1. Name of Person Involved	2. Sex	3. Social Security Number	4. DOB	5. Date of Incident

6. Home Address _____ _____ **Phone ( )**	**7. Time and Day of Incident** _____ AM; _____ PM; day of week _____ **9. Employee's Occupation**	**8. Specific Location of Incident** **Was it on employer's premises?** ☐ yes ☐ no **10. Job Task at Time of Incident**
13. Name and Address of Treating Physician _____ _____ _____ **Phone ( )**	**11. Length of Service** _____Years; _____ Months **14. Employment Category** ☐ Regular, full-time ☐ Temporary ☐ Regular, part-time ☐ Non-employee ☐ Seasonal	**12. Employee was Working** ☐ Alone ☐ With Fellow Workers ☐ Other **15. Experience in Occupation at Time of Incident** ☐ Less than 1 month ☐ 1 to 5 month ☐ 6 months to 1 year ☐ 1 to less than 5 years ☐ 5 or more years
16. Name and Address of Hospital _____ _____ _____ **Phone ( )**	**17. Phase of Employee's Workday at Time of Injury** ☐ During break period ☐ During meal period ☐ Working overtime ☐ Entering or leaving the building ☐ Performing work duties ☐ Other (explain below) **18. Name of employee's immediate Supervisor at time of incident Witnessed Incident?** ☐ Yes ☐ No	
19. Employee's Wage (pay per Hour)	**20. Other Witnesses** _____ _____ _____	
21. Voluntary benefits paid by the employer, if any N/A		

22. PART of BODY INFURIED or AFFECTED

☐ Skull, Scalp	☐ Jaw	☐ Abdomen	☐ Shoulder	☐ Wrist	☐ Knee	☐ Foot
☐ Eye	☐ Neck	☐ Back	☐ Upper Arm	☐ Hand	☐ Thigh	☐ Toe
☐ Nose	☐ Spine	☐ Pelvis	☐ Elbow	☐ Finger	☐ Lower Leg	☐ Ankle
☐ Mouth	☐ Chest	☐ Other Body Part	☐ Forearm	☐ Hip	☐ Other _____	

☐ **Right Side** **or** ☐ **Left Side**

23. NATURE of INJURY or ILLNESS

☐ Puncture	☐ Bruise, Contusion	☐ Skin Disorder	☐ Amputation	☐ Muscle Sprain	☐ Cumulative Trauma Disorder
☐ Laceration	☐ Dislocation	☐ Burn	☐ Insect/Animal Bite	☐ Muscle Strain	☐ Irritation
☐ Fracture	☐ Abrasion	☐ Respiratory	☐ Foreign Body	☐ Hernia	☐ Infection
☐ Heat/Cold Stress	☐ Hearing Loss	☐ Chemical Exp.	☐ Other _____		

24. DISPOSITION

☐ Days away from work # _____
☐ Restricted work days # _____
☐ Date returned to work # _____
Sent to: ☐ Doctor ☐ Hospital

25. DIAGNOSIS

_____
_____
_____

26. SEVERITY

☐ First Aid ☐ Medical Treatment
☐ Lost Work Days ☐ Fatality
☐ Other: Specify
_____

27. WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED TO INCIDENT? ☐ Not Applicable

☐ Close Clearance/Congestion	☐ Floors/Work Surfaces	☐ Inadequate Housekeeping	☐ Defective Tools/Equipment/Vehicle
☐ Hazardous Placement	☐ Inadequate Ventilation	☐ Equipment Failure	☐ Illumination
☐ Inadequate Warning System	☐ Equipment/Workstation Design	☐ Inadequate Guards/Barrier	☐ Inadequate/Improper P.P.E.

28. WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS? ☐ No Substandard Conditions

☐ Abuse or Misuse	☐ Inadequate Supervision	☐ Inadequate Purchasing	☐ Inadequate Engineering
☐ Inadequate Maintenance	☐ Inadequate Tools/Equip..Mat.	☐ Improper Work Surfaces	☐ Wear and Tear
☐ Lack of Knowledge/Training	☐ Improper Motivation	☐ Inadequate Capacity	☐ Lack of Skill

29. WHAT ACTION or INACTION CONTRIBUTED to the INCIDENT? ☐ Not Applicable

☐ Failure to Make Secure	☐ Under Influence Drugs/Alcohol	☐ Failure to Warn/Signal	☐ Inadequate/Improper P. P. E. Use
☐ Nullified Safety/Control Devices	☐ Used Defective Equipment	☐ Horseplay/Distractive Active	☐ Operating at Improper Speed
☐ Used Equipment Improperly	☐ Improper Lifting	☐ Operating Procedure Deviation	
☐ Running/Rushing/Acting in Haste	☐ Improper Loading	☐ Unauthorized Actions	☐ Used Wrong Tool/Equipment
☐ Improper Technique	☐ Improper Position	☐ Servicing/Operating Equipment	
☐ Other _____			

30. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?

_____
_____

30. PROBABLE RECURRENCE

☐ Frequent ☐ Occasional ☐ Rare

31. LOSS SEVERITY POTENTIAL

☐ Major ☐ Serious ☐ Minor

32. PREVENTIVE MEASURES: (What corrective actions have been taken or are planned to prevent a recurrence?)

☐ Improve Enforcement	☐ Improve Clean-up Procedures	☐ Repair/Replace Equipment	☐ Corrective Counseling
☐ Improve Storage/Arrangement	☐ Rotation of Employee	☐ Eliminate Congestion	☐ Improve/Change Work Method
☐ Identify/Improve P. P. E	☐ Install/Revise Guards/Devices	☐ Task Analysis to Be Completed	
☐ Task Analysis/Procedure Revision	☐ Improve Design/Construction	☐ Job Reassignment of Employees	
☐ Use Other Materials/Supplies	☐ Improve Illumination	☐ Mandatory Pre-Job Instructions	
☐ Improve Ventilation	☐ Reinstruction of Employees	☐ Other _____	

33. EMPLOYEE'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ☐ Comments sheet

_____
_____
_____

34. SUPERVISOR'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) ☐ Comments sheet

_____
_____
_____
_____

35. SPECIFIC CORRECTIVE ACTIONS or PREVENTIVE MEASURES TAKEN

Corrective Action Taken	Person Responsible	Target Date	Date Completed

_____ _____ _____
Supervisor's Printed Name Supervisor's Signature Date