

^ d / K E í W / E : h Z W Z ^ K E [ ^ Z W K Z d

Full Name of injured person: \_\_\_\_\_ Department: \_\_\_\_\_ Title: \_\_\_\_\_

Address City/State/Zip: \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date hired: \_\_\_\_\_ (Please check) Male\_\_ Female\_\_

Days normally worked \_\_\_\_\_ Hours worked: \_\_\_\_\_ Shift \_\_\_\_\_

Injury Date: \_\_\_\_\_ Day of Week: \_\_\_\_\_ Occurrence time: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Date employer notified: \_\_\_\_\_ Person who received the first notice? \_\_\_\_\_

Accident Description describe how the incident had occurred \_\_\_\_\_

Nature of injury - state the nature of injury and part(s) of body affected (ex. right knee, lower back, etc.)

What were you doing just before the accident occurred? \_\_\_\_\_

Where did the accident occur (exact location) and facility? \_\_\_\_\_

How did the accident occur? \_\_\_\_\_

What factors led up to or contributed to the accident? \_\_\_\_\_

What were the weather conditions on the date of your accident? \_\_\_\_\_

What tools, equipment or substance was being used? \_\_\_\_\_

Was time away from work necessary? \_\_\_Y \_\_\_N Last Day worked: \_\_\_\_\_ Disability begin date: \_\_\_\_\_

Name and address of any witnesses: \_\_\_\_\_

Have you been provided medical treatment? \_\_\_Y \_\_\_N Will you need medical treatment? \_\_\_Y \_\_\_N

Did you receive care on campus? \_\_\_Y \_\_\_N

If treatment was given away from the worksite, where was it given \_\_\_\_\_ :

Were you treated in the emergency room? \_\_\_Y \_\_\_N Were you hospitalized overnight as an in-patient? \_\_\_Y \_\_\_N

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

^ d/KE // ^hW Zs/^KZ[^ Z WKZdW

When did you first know of the injury? \_\_\_\_\_

List the direct cause(s). List both unsafe actions and unsafe conditions. \_\_\_\_\_

List the root cause(s). \_\_\_\_\_

List the actions that have been or will be taken to remove direct causes listed above by whom and when they are or will be done. \_\_\_\_\_

What additional actions need to be taken in the future? \_\_\_\_\_

Has the employee returned to work? \_\_\_\_\_

If yes, what date? \_\_\_\_\_ Regular Duty\_\_\_ Light Duty\_\_\_

IMMEDIATE ^hW Zs/^KZ[^ ^/'E dhZ W zzzzzzzz \_\_\_\_\_ DATE: \_\_\_\_\_