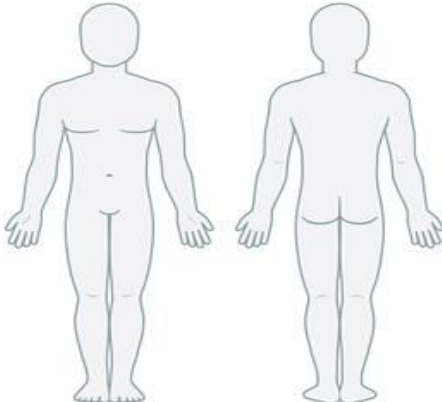


Manager's Report of Incident/Injury

- Ensure injured employee receives appropriate medical care. If necessary, call 911.
- Secure the scene for investigative purposes, e.g. limit access, secure and save equipment/materials involved.
- Complete necessary paperwork, e.g. Report claim to insurance carrier.
- Submit Manager's Report of Incident/Injury to Jennifer Arnold within 24 hours of incident.

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SECTION A – Employee/Volunteer Information			
1. Name:	First Name	Last Name	
2. Employment Status:	Please Select	3. If a Temporary Worker:	Staffing Service
4. Job Title:	Enter Text		Phone No.
SECTION B – Manager Information			
5. Name:	First Name	Last Name	
6. Employment Status:	Enter Text	7. Job Title:	Enter Text
SECTION C – Incident/Injury Information			
8. Type of Incident:	Please Select	9. If Injury:	Please Select
		10. If Other:	Please Specify
11. Date of Incident:	Enter Date	12. Time of Incident:	Time AM <input type="checkbox"/> PM <input type="checkbox"/>
13. Date Reported:	Enter Date	14. Time Reported:	Time AM <input type="checkbox"/> PM <input type="checkbox"/>
15. Type of Location:	Please Select	16. If Other:	Please Specify
17. Name of Location:	Enter Text	18. Location #	Enter Location #
19. Describe the Incident/Injury:	(Please detail events leading to and following the incident/injury) Enter Text		
20. Describe objects, equipment, movement or unsafe act or condition resulting in the Incident/Injury:	Enter Text		
SECTION D – Medical Treatment Information			
21. Describe the injury:	Enter Text		
	(Have employee mark and initial injured body parts on diagram below)		
			
22. Did employee refuse medical treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes:	Have employee initial: _____
23. Has employee returned to work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes:	Enter Date
24. Will employee miss time from work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes:	Please Specify

SECTION E – Incident/Injury Investigation

NOTE: Attach all witness statements to this report.

25. Name of Witnesses:	First Name		Last Name	
	Phone No.:	Enter Phone No.	Email:	Enter Email
	First Name		Last Name	
	Phone No.:	Enter Phone No.	Email:	Enter Email
26. Causation:	<i>(Check all factors contributing to incident/injury)</i>			
	<input type="checkbox"/> Slip, Trip, Fall	<input type="checkbox"/> Improper guarding	<input type="checkbox"/> Improper instruction	
	<input type="checkbox"/> Improper attire	<input type="checkbox"/> Improper maintenance	<input type="checkbox"/> Improper Tool/Tool Use	
	<input type="checkbox"/> Defective equipment	<input type="checkbox"/> Uneven ground	<input type="checkbox"/> Not following procedure	
	<input type="checkbox"/> Unsafe process	<input type="checkbox"/> Distraction/haste	<input type="checkbox"/> Wet floors	
	<input type="checkbox"/> Weather related	<input type="checkbox"/> Failure to lock/tag out	<input type="checkbox"/> Failure to secure	
	<input type="checkbox"/> Lack of proper PPE	<input type="checkbox"/> Ergonomics Issue	<input type="checkbox"/> Operating w/o authority	
	<input type="checkbox"/> Poor housekeeping	<input type="checkbox"/> Inoperative safety device	<input type="checkbox"/> Unsafe position	
	<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"/> Lack of training/skills	
	<input type="checkbox"/> Unaware of surroundings	<input type="checkbox"/> Horseplay	<input type="checkbox"/> Animal or Insect	
	<input type="checkbox"/> Other factors:	Please Specify		
27. Personal Protective Equipment (PPE) used at time of Incident/Injury:	<i>(Check all that apply)</i>			
	<input type="checkbox"/> Foot protection	<input type="checkbox"/> Face/eye protection	<input type="checkbox"/> Hand protection	
	<input type="checkbox"/> Hearing protection	<input type="checkbox"/> Fall protection	<input type="checkbox"/> Respiratory protection	
	<input type="checkbox"/> None			
35. What action(s) do you plan to implement to prevent this type of Incident/Injury from reoccurring?				
Please Specify				
36. Have you instructed the employee/volunteer on how to avoid the reoccurrence? How?				
Please Specify				
37. Was a safety rule/policy violated? If so, has the employee/volunteer been disciplined/coached?				
Please Specify				
38. Manager's Signature:			Date:	Enter Date