Diocese of Green Bay

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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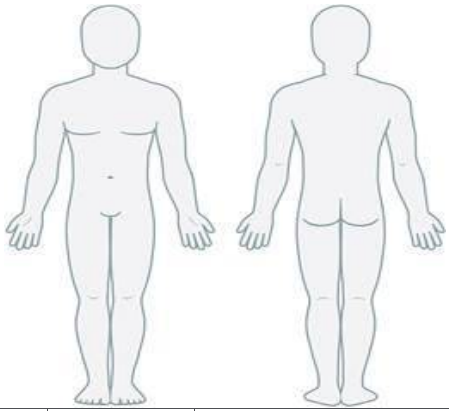
SECTION A – Employee/Volunteer Information			
1. Name:	First Name	Last Name	
2. Employment Status:	Please Select	**3. If a Temporary Worker:**	Staffing Service
4. Job Title:	Enter Text		Phone No.
SECTION B – Manager Information			
5. Name:	First Name	Last Name	
6. Employment Status:	Enter Text	**7. Job 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 ☐ PM ☐
13. Date Reported:	Enter Date	**14. Time Reported:**	Time AM ☐ PM ☐
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 ☐ No ☐	**If yes:**	Have employee initial:_____
23. Has employee returned to work?	Yes ☐ No ☐	**If Yes:**	Enter Date
24. Will employee miss time from work?	Yes ☐ No ☐	**If Yes:**	Please Specify

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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:	*(Check all factors contributing to incident/injury)*			
	☐ Slip, Trip, Fall	☐ Improper guarding	☐ Improper instruction	
	☐ Improper attire	☐ Improper maintenance	☐ Improper Tool/Tool Use	
	☐ Defective equipment	☐ Uneven ground	☐ Not following procedure	
	☐ Unsafe process	☐ Distraction/haste	☐ Wet floors	
	☐ Weather related	☐ Failure to lock/tag out	☐ Failure to secure	
	☐ Lack of proper PPE	☐ Ergonomics Issue	☐ Operating w/o authority	
	☐ Poor housekeeping	☐ Inoperative safety device	☐ Unsafe position	
	☐ Tight working area	☐ Poor ventilation	☐ Chemical hazard or spill	
	☐ Electrical hazard	☐ Poor lighting	☐ Lack of training/skills	
	☐ Unaware of surroundings	☐ Horseplay	☐ Animal or Insect	
	☐ Other factors:	Please Specify		
27. Personal Protective Equipment (PPE) used at time of Incident/Injury:	*(Check all that apply)*			
	☐ Foot protection	☐ Face/eye protection	☐ Hand protection	
	☐ Hearing protection	☐ Fall protection	☐ Respiratory protection	
	☐ 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	

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