#

# WORKPLACE INCIDENT REPORT

#

#  Check Box: [ ]  INJURY [ ]  ILLNESS [ ]  NEAR MISS

 Email completed form to: tnwclaims@tnwinc.com or fax to: 800-748-6159

## A. EMPLOYEE INFORMATION: ALL FIELDS REQUIRED

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EMPLOYEE’S NAME      | M/F      |  DOB |  COMPLETE SSN           | JOB TITLE/CLASSIFICATION      |
| EMPLOYEE ID NUMBER      | FT[ ]  | Temp[ ]  | Seasonal[ ]  | DATE OF INCIDENT      |  DATE OF HIRE      | TIME WORK DAY BEGAN      | TIME OF INCIDENT (AM / PM) |
| AGENCY #      | DEPT      | OVERTIME?Y [ ]  N [ ]  | SHIFT?1 [ ]  2 [ ]   3 [ ]  | HAS EMPLOYEE LOST TIME FROM WORK? [ ]  Yes [ ]  No | HAS EMPLOYEE RETURNED TO WORK? [ ] Yes [ ] No If yes, what date?       |
| AVERAGE WEEKLY WAGE      | AT THE TIME OF THE INCIDENT THE EMPLOYEE WAS: [ ]  on break [ ]  on lunch [ ]  arriving/leaving work for the day [ ]  performing the following task or tasks:      |
| EMPLOYEE’S HOME ADDRESS       | EMPLOYEE’S PHONE # Home & Cell & EMAIL       | SUPERVISOR’S NAME, PHONE # & EMAIL      |

#### B. INCIDENT DETAILS: Is there any reason to question how this incident occurred? [ ] Yes [ ] No Explain:

|  |  |
| --- | --- |
| LOCATION/ADDRESS (where injury occurred):      | DESCRIBE WHAT HAPPENED:      |

#### C. WAS MEDICAL TREATMENT REQUIRED? [ ]  Yes [ ]  No

|  |
| --- |
| 1. If yes, what type of treatment and where was it received?      2. Is there a follow up appointment and if so, when is it?      3. Was employee put on restricted duty?       4. Can restricted duty be accomodated?       |

**D. PART OF BODY INVOLVED** (be specific: left, right, upper, lower, etc.)

|  |
| --- |
|       |

#### E. TYPE OF INCIDENT

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [ ]  | Caught on or in | [ ]  | Ingestion | [ ]  | Inhalation  | [ ]  | Fall-same level  | [ ]  | Bitten |
| [ ]  | Overexertion | [ ]  | Electrical  | [ ]  | Chemical – skin  | [ ]  | Fall-different level  | [ ]  | Lifting  |
| [ ]  | Struck by/against  | [ ]  | Slip or Trip | [ ]  | Explosion  | [ ]  | Heat/Cold exposure  | [ ]  | Cut  |
| [ ]  | Auto accident  | [ ]  | Cumulative injury  | [ ]  | Puncture | [ ]  | Other       |  |  |

#### F. WITNESS TO INJURY (attach witness statement to investigation page 2)

|  |  |  |  |
| --- | --- | --- | --- |
| NAME #1:      | PHONE #      | NAME #2:      | PHONE #       |

#### G. FORM COMPLETED BY:

|  |  |  |
| --- | --- | --- |
| Print Name & Title |  Phone # & Email Address | Date & Time Injury Reported to Agency |
|       |       |        a.m./p.m. |
|       |       |        a.m./p.m. |

**REQUIRED**-may be sent in separately from page 1

#### H. SUPERVISOR’S INVESTIGATION OF INCIDENT

|  |
| --- |
| WHAT HAPPENED? (Be specific; include heights, weight, repetitions, dimensions, lighting etc.)      |

#### I. WHY DID IT HAPPEN?

|  |
| --- |
| ROOT CAUSE #1:     ROOT CAUSE #2:     ROOT CAUSE #3:      |

 **J. WHAT CORRECTIVE ACTION IS BEING TAKEN TO ELIMINATE POTENTIAL FOR FURTHER INJURY OR ILLNESS**?

|  |
| --- |
| What specifically is being done? How are we addressing root causes, behavior, hazards, training?       |

#### K. DISCIPLINARY ACTION TAKEN: [ ]  YES [ ]  NO

|  |
| --- |
| Describe:       |

**L. FALL FROM DIFFERENT LEVEL INFORMATION:**

|  |  |
| --- | --- |
| Height:      | Was a ladder involved? Describe:      |

#### M. CAUSE OF INCIDENT – UNSAFE ACT: [ ]  BY INJURED PERSON -or- [ ]  BY OTHER PERSON (NAME):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Failure to warn or signal | [ ]  | Working/reaching moving equipment | [ ]  | Overloading equipment or containers |
| [ ]  | Making safety devise inoperative | [ ]  | Failure to shut off or lockout | [ ]  | Wearing unsafe attire, jewelry etc. |
| [ ]  | Not observing where walking or driving  | [ ]  | Moving objects too heavy  | [ ]  | Disregard instructions |
| [ ]  | Operating at unsafe speed | [ ]  | Not wearing PPE  | [ ]  | Horseplay  |
| [ ]  | Operating without safety device  | [ ]  | Operating without authority | [ ]  | Lack of training  |
| [ ]  | Taking unsafe position | [ ]  | Using unsafe tools or equipment | [ ]  | No unsafe act  |
| [ ]  | Negligence | [ ]  | Employee misconduct | [ ]  | Other       |

#### N. CAUSE OF INCIDENT – UNSAFE CONDITION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Hazardous arrangement  | [ ]  | Poor Housekeeping  | [ ]  | Wet/slippery/icy floor or ground  |
| [ ]  | Insufficient lighting  | [ ]  | Unsafe design  | [ ]  | Other       |
| [ ]  | Insufficient guarding  | [ ]  | Ergonomic deficiency  | [ ]  | Other       |
| [ ]  | Faulty machine or equipment  | [ ]  | Hazardous work method  | [ ]  | Other       |
| [ ]  | Insufficient ventilation  | [ ]  | Poor air quality  | [ ]  | Other       |

#### O. CAUSE INFORMATION

|  |  |  |
| --- | --- | --- |
|  YES | NO |  |
| 1.[ ]  | [ ]  | Was employee doing his/her regularly assigned job? Explain a “no” answer below. |
| 2.[ ]  | [ ]  | Did you (supervisor) provide proper instruction on how to do the job safely? Explain a “no” answer below. |
| 3.[ ]  | [ ]  | Was employee doing this job as you had instructed? Explain a “no” answer below. |
| 4.[ ]  | [ ]  | Was proper equipment provided? Explain a “no” answer below. |
| 5.[ ]  | [ ]  | Was the employee using the equipment? Using it properly? Explain a “no” answer below. |
| 6.[ ]  | [ ]  | Have you had similar incidents with this or other equipment in you area? Explain a “yes” answer below. |
| Additional comments from above:       |

#### P. SAFETY INVESTIGATION AND FOLLOW-UP

|  |  |  |
| --- | --- | --- |
| YES | NO |  |
| [ ]  | [ ]  | Was the investigation thorough? |
| [ ]  | [ ]  | Was corrective action taken? |
| [ ]  | [ ]  | Did the supervisor make every attempt to help eliminate the unsafe act or hazard? |
| [ ]  | [ ]  | Did the employee make every attempt to help eliminate the unsafe act of hazard? |
| Explanation and recommendations:      |

#### Q. INVESTIGATION COMPLETED BY:

|  |  |  |
| --- | --- | --- |
| Print Name & Title      |  Phone # & Email Address      | Date Completed      |