# 

# WORKPLACE INCIDENT REPORT

# 

# Check Box: INJURY ILLNESS NEAR MISS

Email completed form to: [tnwclaims@tnwinc.com](mailto: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 |