

Accidental Injury, Occupational Illness, Workplace Incident INCIDENT REPORT

Complete all sections. See SAFETY POLICIES AND PROCEDURES MANUAL S25.20 for instructions. Also used to report property damage.

LAST NAME OF AFFECTED PARTY 1	FIRSTNAME AND MIDDLE INITIAL 2	ADDRESS 3	WSUID NO. 4	INCIDENT DATE 5
DEPARTMENT AND COLLEGE/DIVISION 6			SEX 7 <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH 8
NAME OF PREPARER 9	TITLE OF PREPARER 10	PREPARER TELEPHONE NUMBER 11	MAIL CODE 12	DATE PREPARED 13
Check if applicable to incident: 14 <input type="checkbox"/> ACCIDENTAL INJURY <input type="checkbox"/> OCCUPATIONAL ILLNESS <input type="checkbox"/> PROPERTY DAMAGE <input type="checkbox"/> MOTOR VEHICLE <input type="checkbox"/> WORKPLACE VIOLENCE				
STATUS 15 <input type="checkbox"/> STUDENT <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> VISITOR <input type="checkbox"/> EMPLOYEE			JOB TITLE IF EMPLOYEE 16	
DATE OF HIRE 17				
HRS/DAY EMPLOYED 18	DAYS/WK EMPLOYED 19	SCHEDULED DAYS OFF 20	RATE OF PAY 21 PER <input type="checkbox"/> MO <input type="checkbox"/> HR	
TIME EMPLOYEE STARTED WORK 22 <input type="checkbox"/> AM <input type="checkbox"/> PM		TIME OF INCIDENT 23 <input type="checkbox"/> AM <input type="checkbox"/> PM		CHECK IF TIME CAN'T BE DETERMINED 24 <input type="checkbox"/>
NAME OF SUPERVISOR 25	TELEPHONE NUMBER 26	SUPERVISOR WAS NOTIFIED 27 DATE _____ TIME _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
COMPLETE DESCRIPTION OF WHAT THE PARTY WAS DOING JUST BEFORE THE INCIDENT OCCURRED (Example: Climbing ladder while carrying roof materials.) 28				
COMPLETE DESCRIPTION OF INCIDENT, INCLUDE SPECIFIC ACTIVITY DURING INCIDENT (LIFTING, PUSHING, ETC.) (Example: When ladder slipped on wet floor, worker fell 20 ft.) 29				
SPECIFY INJURY OR ILLNESS AND BODY PARTS AFFECTED (Example: Strained back) 30				
DESCRIBE THE OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE PARTY (Example: Concrete floor) 31				
EXACT LOCATION OF INCIDENT (BUILDING, FLOOR, GEOGRAPHICAL LOCATION) 32				
NAMES AND PHONE NUMBERS OF WITNESSES OR OTHERS INVOLVED IN INCIDENT (Attach Witness/Injured Person Statements. See S25.25.5.) 33				
INJURY/ILLNESS SEVERITY (See S25.20.4-5.) 34				
<input type="checkbox"/> FIRST AID OR MEDICAL TREATMENT (Check all that apply) ___ Use of bandages (e.g., butterfly bandages, Steri-Strips); ___ Nonrigid braces and wraps; ___ Finger guards; ___ Eye patches; ___ Removal of splinters with tweezers; ___ Cleaning, flushing, or soaking surface wounds; ___ Simple irrigations to flush foreign bodies from the eye; ___ Tetanus shots; ___ X-rays; ___ Blood tests; ___ Prescription medications*; ___ Sutures, staples*; ___ Casts, rigid braces*; ___ Physical therapy*; ___ Chiropractic treatment*; ___ Surgery*; ___ Other. * This treatment is considered to be a medical treatment. If medical treatment is involved, supervisor must complete a Supervisor's Accident Investigation Report. See SPPM S25.25.				
<input type="checkbox"/> NO TREATMENT REQUIRED <input type="checkbox"/> FATALITY, ENTER DATE:				
TIME LOSS (Check all that apply.) 35				
<input type="checkbox"/> RETURN TO WORK THE NEXT DAY		<input type="checkbox"/> RESTRICTED ACTIVITY/JOB TRANSFER (See S25.20.5-6.)		BEGIN DATE: _____ RETURN DATE: _____
<input type="checkbox"/> NO TIME LOSS		<input type="checkbox"/> LOST WORKDAYS, NOT AT WORK** (See S25.20.6.)		BEGIN DATE: _____ RETURN DATE: _____
** If absent for the next full shift or subsequent shifts, supervisor must complete Supervisor's Accident Report and send a copy of employee's Time/Leave Report to Human Resource Services.				
WORKDAY PHASE 36				
<input type="checkbox"/> PERFORMING WORK <input type="checkbox"/> MEAL PERIOD <input type="checkbox"/> REST PERIOD <input type="checkbox"/> ENTERING/LEAVING <input type="checkbox"/> CHRONIC EXPOSURE <input type="checkbox"/> OTHER, SPECIFY: _____				
NAME AND ADDRESS OF MEDICAL PROVIDER (HOSPITAL, DOCTOR, CLINIC, ETC.) 37			TREATED IN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO 38	
			HOSPITALIZED OVERNIGHT AS INPATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 39	
SIGNATURE OF INVESTIGATING SUPERVISOR		DATE 40	SIGNATURE OF CHAIR/DEAN	
X			X	

Route original and one copy to Human Resource Services (campus mail code 1014) within 24 hours.
Route one copy to the departmental safety committee. Route one copy to the employee/student.

EH&S OFFICE USE ONLY	CASE NUMBER	<input type="checkbox"/> RECORDABLE	<input type="checkbox"/> NONRECORDABLE
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