

## EMPLOYEE – PUBLIC Incident/Accident Report Form

### Claimant Information

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Name: _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Age _____
				Medicare Recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address _____		Phone Number _____		
Location of Incident: _____	_____	Task being Performed: _____	_____	
Name of Witness #1: _____	_____	Name of Witness #2: _____	_____	
Phone # of Witness #1: _____	_____	Phone # of Witness #2: _____	_____	

### Incident Information

Incident date: ____ / ____ / ____	Day of week: _____	Time: ____ : ____	AM <input type="checkbox"/> PM <input type="checkbox"/>
Location of incident? _____			
Was incident reported when it occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**Describe Clearly How the Incident Occurred:**


**Witnesses Account of Incident:**


**Analysis (What Acts and / or conditions directly contributed to the incident?):**


**Corrective Action (What actions have or will be taken to prevent recurrence):**


Signature of Claimant: _____	Date: _____
Signature of Witness #1: _____	Date: _____
Signature of Witness #2: _____	Date: _____

### Bodily Injury Information

Cause of injury: <small>(Describe unsafe conditions or unsafe acts):</small>	_____		
Client injured by:	<input type="checkbox"/> Self-inflicted	<input type="checkbox"/> Staff member	<input type="checkbox"/> Other member
Incident Occurred:	<input type="checkbox"/> Entering facility	<input type="checkbox"/> Inside of facility	<input type="checkbox"/> While exercising
	<input type="checkbox"/> Exiting facility	<input type="checkbox"/> Outside of facility	<input type="checkbox"/> Other: _____
Specific area where incident occurred:	_____		

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<b>Type of injury:</b>	<input type="checkbox"/> Abrasion/scratch	<input type="checkbox"/> Fracture/break	<input type="checkbox"/> Sprain/strain
	<input type="checkbox"/> Contusion/bruise	<input type="checkbox"/> Laceration/cut	<input type="checkbox"/> Other: _____
<b>Action Taken:</b>	<input type="checkbox"/> None	<input type="checkbox"/> First Aid treatment by Staff	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Referred to Doctor (Doctor's Name: _____)	<input type="checkbox"/> Referred to nurse (Nurse's Name: _____)	<input type="checkbox"/> Transported to hospital: Name of hospital: _____
	Person Notified: _____		Time Notified: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
<b>Treatment Provided:</b>	<input type="checkbox"/> None	<input type="checkbox"/> First aid	<input type="checkbox"/> Medical office visit
	<input type="checkbox"/> Emergency room /outpatient	<input type="checkbox"/> Inpatient services	<input type="checkbox"/> Other: _____
<b>Part of body injured:</b>	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Eye	<input type="checkbox"/> Leg
	<input type="checkbox"/> Arm	<input type="checkbox"/> Foot / toes / ankle	<input type="checkbox"/> Mouth / Teeth
	<input type="checkbox"/> Back	<input type="checkbox"/> Hand / fingers	<input type="checkbox"/> Neck
	<input type="checkbox"/> Chest	<input type="checkbox"/> Head / skull	<input type="checkbox"/> Nose
	<input type="checkbox"/> Ear	<input type="checkbox"/> Knee	<input type="checkbox"/> Other: _____

## Supervisor's Report of Accident

**Director/Manager/ Supervisor's Name:** \_\_\_\_\_

### Basic Rules for Incident Investigation

- Find the cause to prevent future incidents - Use an unbiased approach during investigation
- Interview witnesses & injured employees at the scene - conduct a walkthrough of the incident
- Conduct interviews in private - Interview one witness at a time.
- Get signed statements from all involved.
- Take photos or make a sketch of the incident scene.
- What hazards or unsafe conditions are present - what unsafe acts contributed to accident
- Ensure hazardous conditions are corrected immediately.

## Supervisor's Root Cause Analysis

**Check ALL that apply to this incident**

Unsafe Acts		Unsafe Conditions	
By-passing or avoiding safety devices	<input type="checkbox"/>	Damaged flooring, tiles or surfaces	<input type="checkbox"/>
Drug or alcohol use	<input type="checkbox"/>	Inadequate guarding of hazards	<input type="checkbox"/>
Entered area without authority	<input type="checkbox"/>	Insufficient lighting	<input type="checkbox"/>
Failure to warn (no warning signs)	<input type="checkbox"/>	Lack of flooring covering (mats)	<input type="checkbox"/>
Horseplay	<input type="checkbox"/>	Lack of safety devices (handrails)	<input type="checkbox"/>
Improper maintenance of area	<input type="checkbox"/>	Obstructed view	<input type="checkbox"/>
Insufficient knowledge of area	<input type="checkbox"/>	Poor housekeeping	<input type="checkbox"/>
Moving at improper speeds	<input type="checkbox"/>	Poor surface conditions	<input type="checkbox"/>
Safety rule violation	<input type="checkbox"/>	Slippery / wet conditions (spills)	<input type="checkbox"/>
Other:	<input type="checkbox"/>	Tripping hazards / congestion in area	<input type="checkbox"/>
		Other:	<input type="checkbox"/>
<b>Date</b>		<b>Date</b>	
Re-Training Assigned		Unsafe Condition Guarded	
Re-Training Completed		Unsafe Condition Corrected	
<b>Supervisor Signature:</b> _____		<b>Date:</b> _____	