

AUGUSTANA COLLEGE INCIDENT REPORT

INJURY	<input type="checkbox"/>
ILLNESS	<input type="checkbox"/>
NEAR MISS	<input type="checkbox"/>

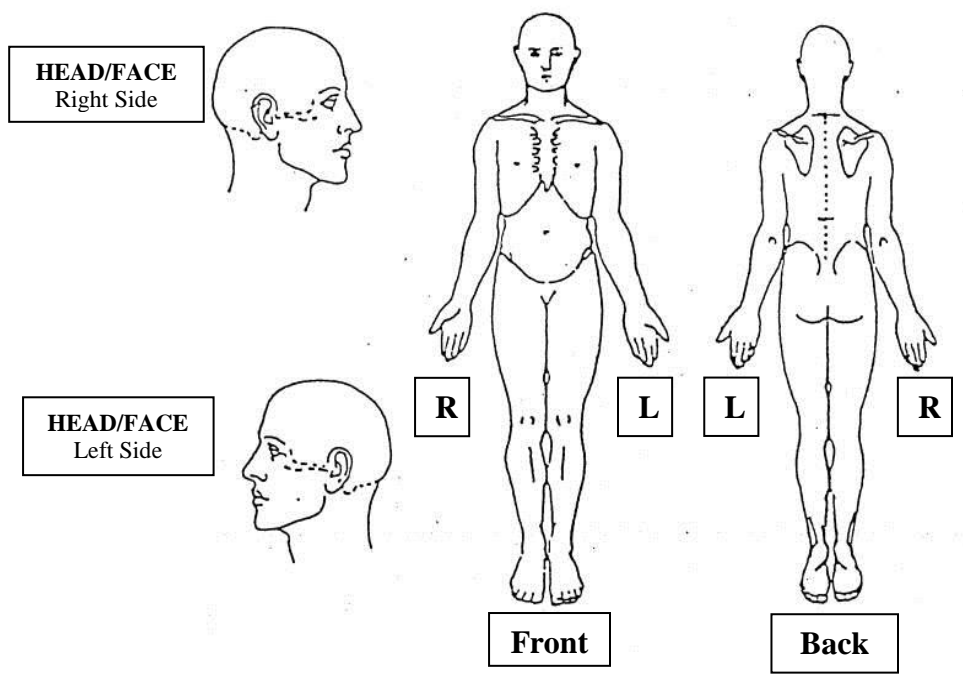
CLAIM# _____ (ASSIGNED BY TRAVELER'S INSURANCE)

This form should be used to report incidents involving work related injuries or illness for all employees of the college. Please complete every space, or mark it "NA" if not applicable. The college is required to track this information and report it to the government (OSHA).

EMPLOYEE NAME: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		SOCIAL SECURITY NUMBER _____	DATE OF BIRTH: DATE OF HIRE: WAGE:
JOB TITLE	DEPARTMENT		SUPERVISOR
HOME PHONE #	WORK PHONE #		DOES THIS EMPLOYEE WORK FOR OTHER DEPARTMENTS ON CAMPUS? <input type="checkbox"/> YES <input type="checkbox"/> NO
DATE OF INJURY: ___/___/___ DATE REPORTED: ___/___/___ REPORTED TO: _____	TIME EMPLOYEE BEGAN SHIFT: _____AM/PM (CIRCLE ONE) TIME OF INJURY: _____AM/PM (CIRCLE ONE)		EVENT OCCURRED: <input type="checkbox"/> BEFORE <input type="checkbox"/> DURING <input type="checkbox"/> AFTER SCHEDULED WORK SHIFT
ACCIDENT RESULTED IN (CHECK ALL THAT APPLY): <input type="checkbox"/> ON SITE FIRST AID <input type="checkbox"/> CLINIC VISIT <input type="checkbox"/> RESTRICTED DUTY <input type="checkbox"/> AFFECTED HEARING <input type="checkbox"/> ILLNESS <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> LOST TIME <input type="checkbox"/> SKIN DISORDER <input type="checkbox"/> NO INJURY/ILLNESS <input type="checkbox"/> HOSPITALIZATION <input type="checkbox"/> CHEMICAL EXPOSURE <input type="checkbox"/> RESPIRATORY CONDITION <input type="checkbox"/> PROPERTY DAMAGE <input type="checkbox"/> AMBULANCE <input type="checkbox"/> UNCONSCIOUSNESS FOR ANY LENGTH OF TIME			
COMPLETE HOME ADDRESS (STREET, CITY, STATE, and ZIP) _____			
INCIDENT DESCRIPTION (DESCRIBE WHAT THE EMPLOYEE WAS DOING, THE INCIDENT, AND DETAILS ABOUT CHEMICAL EXPOSURE, IF ANY) _____			
NATURE OF INJURY (SCRATCH, CUT, BRUISE, ETC.)		LOCATION OF INCIDENT (EX. OLD MAIN ROOM 115, CORRIDOR ON 2ND FLOOR OF SCIENCE BLDG, WESTERLIN PARKING LOT)	
PART OF BODY INJURED (LEFT RING FINGER, RIGHT ANKLE, ETC.)		WITNESSED BY (NAME AND CONTACT INFORMATION)	
FACTORS: WHAT CONDITIONS, EQUIPMENT, SUBSTANCE OR OBJECT CONTRIBUTED TO THE INCIDENT? (EX. OIL ON FLOOR, BROKEN MACHINE GUARD, DID NOT LOCK OUT MACHINE, NOT WEARING SAFETY GLASSES, OLD WOODEN LADDER) _____			
MEDICAL CARE PROVIDED – DATE OF SERVICE: _____ BY: <input type="checkbox"/> Concentra – 555 Valley View Dr. Moline, IL 61265 (309) 764-9675 <input type="checkbox"/> OTHER:			
WAS EMPLOYEE HOSPITALIZED OVERNIGHT? WHERE? <input type="checkbox"/> YES <input type="checkbox"/> NO		LAST DATE EMPLOYEE WORKED	
HOW CAN WE PREVENT THIS FROM HAPPENING AGAIN TO THIS PERSON OR OTHERS AT THE COLLEGE? _____			
EMPLOYEE RESPONSIBLE FOR CORRECTIVE ACTION			
NAME:	TITLE:	DATE:	

EMPLOYEE STATEMENT

PLEASE CIRCLE ALL INJURED BODY PARTS AS A RESULT OF THIS INCIDENT



EMPLOYEE SIGNATURE: _____ DATE: _____