# REPORT OF EMPLOYEE PERSONAL INJURY/ACCIDENT



INSTRUCTIONS: Part I of this report should be completed ASAP and by the injured employee (if possible). The immediate supervisor or appropriate manager shall immediately, upon notification of an accident, perform an investigation and fill out Part 2 of this form. The original report is to be forwarded to the Ecology Safety Office (Claims Coordinator); see distribution below.

***CHECK ALL THAT APPLY***: [ ]  ACCIDENT [ ]  INJURY [ ]  DAMAGE (vehicle or equip) [ ]  INCIDENT [ ]  HAZARD [ ]  NEAR MISS [ ]  ILLNESS

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| PART I -- EMPLOYEE'S REPORT |
| 1. Injured Employee's Name (Last, First MI) | 2. [ ]  Male [ ]  Female | 3. Age | 4. Who was with you?  |
| 5. Employee Status: [ ]  Permanent [ ]  Temporary [ ]  Intermittent [ ]  Project [ ]  Part Time [ ]  Seasonal [ ]  Intern(check all that apply) [ ]  Other (explain):  | 6. Home Phone Number  |
| 7. Job/Position Title | 8. Region/Program/Section | 9. Work Phone |
| 10. Date of mishap  | 11. Time of mishap: [ ]  am [ ]  pm | 12. Last day worked | 13. Date expected to return to work |
| 14. Exact location of mishap  | Work activity being performed at time of mishap  | 16. Were you alone? [ ]  Yes [ ]  No  |
| 17. Was protective equipment being worn? [ ]  Yes [ ]  No Describe the PPE you were wearing: |
| 18. Description of mishap |
| 19. Did you report this mishap? [ ]  Yes [ ]  No If yes, when:      To whom?  | 20. Whom may we contact for details regarding the above mishap?  |
| 21. How might this mishap have been prevented?  | 22. Sign & Date      |
| PART II – IMMEDIATE SUPERVISOR'S REPORT |
| 1. Supervisor's Name | 2. Phone Number | 3. Date and time reported to you |
| 4. Was this employee on the job at time of injury? [ ]  Yes [ ]  No Please explain:  |
| 5. Describe, in your own words, the facts as you know them surrounding the above mishap |
| 6. Did Employee: YES NO UnknownReceive First Aid on scene? [ ]  [ ]  [ ] See Doctor? [ ]  [ ]  [ ] Go To a Hospital or Clinic? [ ]  [ ]  [ ] Initiate a Claim? [ ]  [ ]  [ ] Date of initial visit & name of medical provider/facility: | 7. Indicate body location and type of injury or illness: |
| [ ]  Head [ ]  Hands [ ]  Knees[ ]  Eyes [ ]  Legs [ ]  Neck[ ]  Trunk [ ]  Toes [ ]  Back[ ]  Arms [ ]  Internal [ ]  OtherDescribe:  | [ ]  Wound [ ]  Amputation [ ]  Bruise[ ]  Strain/Sprain [ ]  Burn [ ]  Laceration[ ]  Hernia [ ]  Foreign body [ ]  Concussion[ ]  Fracture [ ]  Skin [ ]  OtherDescribe:  |
| 8. Do you think corrective and/or preventive measures are needed? [ ]  Yes [ ]  No If yes or no, please explain: |
| 9. Supervisor Signature & Date      | 10. Regional Safety Office, check all that apply: [ ]  Investigated [ ]  Reviewed only[ ]  No action necessary [ ]  Action pending [ ]  Copy to files **Initial & Date**       |

DISTRIBUTION: Original to the Ecology Safety Office (Claims Coordinator); NOTE: Attach additional sheets to this report if more space is needed for your comments. 1-Supervisor; 1-Safety Committee Chair; 1-Employee

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