# REPORT OF EMPLOYEE PERSONAL INJURY/ACCIDENT

ECO-BW

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  Other  Describe: | | | | | | | Wound  Amputation  Bruise Strain/Sprain  Burn  Laceration Hernia  Foreign body  Concussion Fracture  Skin  Other  Describe: | | | | | |
| 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

**ECY 010-151 (Rev 03/2004)**