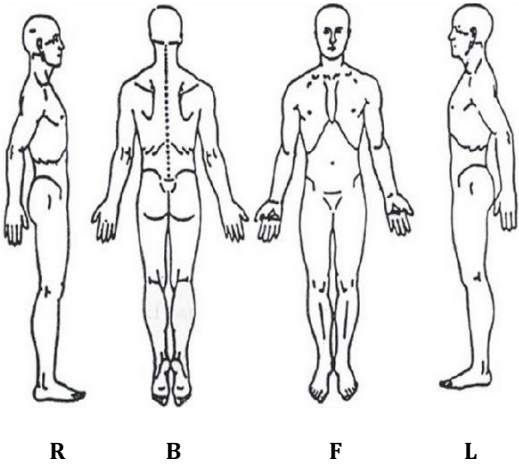


Personal Information			
Name:		WIN:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Contractor <input type="checkbox"/> Other, describe:			
Part of Body Affected:  	Nature of Injury: <input type="checkbox"/> Cut / Laceration / Puncture <input type="checkbox"/> Illness <input type="checkbox"/> Bruises / Contusion <input type="checkbox"/> Sprain / Strain / Hernia <input type="checkbox"/> Fracture / Dislocation <input type="checkbox"/> Burns (heat & chemical) <input type="checkbox"/> Amputation <input type="checkbox"/> Puncture <input type="checkbox"/> Dermatitis <input type="checkbox"/> Concussion <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Abrasion / Scratch <input type="checkbox"/> Muscle Torn <input type="checkbox"/> Visual Irritation <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heat Stroke <input type="checkbox"/> Respiratory <input type="checkbox"/> Inflamed or Irritated <input type="checkbox"/> Muscles, Tendons <input type="checkbox"/> Other: _____	Type of Injury: <input type="checkbox"/> Struck Against <input type="checkbox"/> Struck by Flying Object <input type="checkbox"/> Struck by Moving Object <input type="checkbox"/> Caught in Between <input type="checkbox"/> Fall to Different Level <input type="checkbox"/> Trip - Slip / Fall <input type="checkbox"/> Lift or Lower <input type="checkbox"/> Push or Pull <input type="checkbox"/> Trip-Slip (not a fall) <input type="checkbox"/> Stepped on <input type="checkbox"/> Contact with temp. extreme <input type="checkbox"/> Contact with elect. current <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Twisting <input type="checkbox"/> Reaching / Stretching <input type="checkbox"/> Extreme / Abnormal Movement <input type="checkbox"/> Contact with Toxins <input type="checkbox"/> Chemical Splash <input type="checkbox"/> Other: _____	
Was Individual Sent For Medical Attention: <input type="checkbox"/> Yes <input type="checkbox"/> No		Was First Aid Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Incident
Exact Location of the Incident:
Date: _____ Time: _____
Witness(es):
Witness Statements Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No      Photographs Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No Claim Information Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No
What Personal Protective Equipment was being used:
Describe the incident:

Report		
Preparer's Name: _____	Department: _____	Date: _____
Distribution List: <input type="checkbox"/> EHS Committee <input type="checkbox"/> HR <input type="checkbox"/> Campus Police <input type="checkbox"/> Facilities <input type="checkbox"/> Department/Supervisor <input type="checkbox"/> Other: _____		

## Accident/Incident Investigation Report Workplace Safety Committee

Investigations should be completed by the area supervisor, HR, EHS or University Police. Remember that the purpose of this investigation is not to find fault or assess blame. It is to pinpoint the cause of the accident / incident and take appropriate action to prevent recurrence and reduce injuries.

<b>Factors:</b>
<b>Activities</b> – List the specific actions or activities that may have contributed to incident and why:
<b>Factors</b> – Identify PPE (personal protective equipment) used, apparel worn, training, job knowledge/planning, preoccupation or any physical factors involved and why:
<b>Practices</b> – List any accepted and/or unapproved or unsafe practices that were being performed and why:
<b>Tools, Equipment, &amp; Machinery</b> – List all equipment that was involved including the condition and appropriateness of use and why:
<b>Environment</b> – Identify the environmental factors including weather conditions, housekeeping, working / walking surfaces, lighting, etc. that may have contributed to the incident and why:

<b>Corrective Actions:</b>		
Action:	Target Completion Date:	Responsible Person:

<b>Report</b>			
Investigator's Name:	Department:	Date:	
Distribution List:	<input type="checkbox"/> EHS Committee	<input type="checkbox"/> HR	<input type="checkbox"/> Campus Police
	<input type="checkbox"/> Department/Supervisor	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Facilities