ASSOCIATE INCIDENT/INJURY REPORT FORM (WORKERS COMPENSATION)

IMPORTANT: Print, fill out and sign this form. Email a scanned copy to hr@teamschierl.com

ASSOCIATE INFORMATION

Associate Name: _____

Associate Number (if applicable): _____

Location: _____

Associate Contact Phone Number: _____

INCIDENT INFORMATION

Date of Incident: _____

Time of Incident: _____

Exact Location of Incident:

_____

_____

INJURY INFORMATION

☐ **Cut/Laceration**
☐ **Burn**
☐ **Slip/Fall**
☐ **Strain/Sprain**
☐ **Head Injury**
☐ **Other**: _____

Body Part Injured and Description of Injury

_____

_____

_____

Description of Incident

Please describe exactly what happened, including events leading up to the injury.

_____

_____

_____

WITNESS INFORMATION

Witness

Name: _____

Phone Number: _____

Statement:

_____

_____

_____

MEDICAL TREATMENT

Was first aid provided?

☐ No ☐ Yes

If yes, by whom and what treatment?

_____

_____

_____

Were emergency services called?

☐ No ☐ Yes (please provide any additional information below)

_____

_____

_____

If emergency services were not contacted, was medical treatment from an outside healthcare provider required?

☐ No ☐ Yes

If yes:

Clinic/Hospital Name: _____

Date of Treatment: _____

ROOT CAUSE OF THE INCIDENT

Select the primary root cause of the incident:

☐ **Environment** – The mechanical, physical, or equipment conditions were in need of maintenance or failed.

☐ **Knowledge** – There was a lack of education and/or ability to perform the job safely (e.g., insufficient training, unclear instructions, lack of experience).

☐ **Motivation** – There was a lack of desire to perform the work safely (e.g., rushing, taking shortcuts, not following procedures, complacency).

☐ **Other** – Please explain below.

What actions have been taken to help prevent future incidents?

_____

_____

_____

REPORT COMPLETION

Report Completed By (Print Name): _____

Title: _____

Date Completed: _____

Signature: _____

ASSOCIATE SIGNATURE

Signature: _____

Date: _____