Cary Institute of Ecosystem Studies Work-Related Accident/Illness Report Form

FORM MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES WITHIN SEVEN DAYS OF THE INCIDENT

Employee: complete front & return to supervisor
Supervisor: complete back & return to HR

Today's Date: _____

This form is to be completed for work-related accidents and illnesses.

Please provide information regarding the person(s) involved in accident/illness:

Full Name: _____ Job Title: _____
Home Address: _____
Home Phone Number: _____ Age: _____ # of Dependents: _____

Please provide information regarding the accident/illness:

1) Date of accident/illness: _____ Time of accident/illness: _____
Location of accident/illness: _____
2) Description of accident/illness: (Include details; equipment, tools, chemicals involved, etc.)
_____
_____
3) Description of injury and/or property damage as a result of accident/illness (if any):
{Please be as detailed as possible indicating parts of body affected – e.g. bruised right knee}
_____
_____
3a) Was Medical Care Provided? *(circle one)* Yes or No
If yes, when: _____
Name, Address & Phone # of Dr. and/or Hospital:
_____
_____
_____
3b) Type of Treatment Provided by Dr. /Hospital:
_____
3c) Was any work time lost? *(circle one)* Yes or No
If yes, indicate # of days and/or hours out and date of return to work:
Days Out: _____Date returned: _____
4) Date I first informed Supervisor/Employer of accident/illness/injury: _____
5) Basic Cause(s) of accident/illness: {Please specify if you were aware of any unsafe act(s) and/or conditions}
_____
5a) Did you receive training/orientation enabling you to prevent/avoid this accident?
_____
5b) If not, list recommended corrective action:
_____
6) What could have prevented this accident from occurring?
_____
6b) Recommended corrective action:
_____
7) Were there any witnesses to the accident? If so, please provide their name and phone #:
_____

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To be completed by Human Resources:
Investigation conducted by: _____ Title: _____ Date: _____
EE SS# _____ EE DOH: _____ EE Marital Status: _____
Date of Birth: _____ Currently Working: (Check one) Full Time_____ Part Time _____
Logged In: (check one) First Aid Only Log: _____ OSHA Log: _____ Notified ACTEC on: _____ (date)

Cary Institute of Ecosystem Studies — Supervisor Investigation

Supervisor's Name: _____Title: _____

Please check all appropriate boxes:

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You are receiving this form because the person involved in an accident/illness works under your supervision. All accident/illnesses at Cary Institute are investigated to learn from them in an attempt to avoid repetition. Please note that the information requested may be required should a worker's compensation claim need to be filed – please ensure all areas are as complete as possible. To assist in this investigation process, please:

- **Read carefully the accident/illness report on the front side of this form**
- **Discuss with employee this accident/illness and how/if it could have been prevented**
- **Please meet with the employee to review the questions below.**
- **Both you and the employee need to sign the completed form, and return to HR.**

1) Could this accident/illness have been avoided: If so, how?

_____

_____

_____

2) Did your orientation and training of this individual cover procedures relevant to the accident/illness?

_____

_____

3) As a result of this accident/illness, will you revise your orientation and training in any way?

_____

_____

4) Are there actions others could take to minimize a recurrence of this type of accident/illness?

_____

_____

5) Do you have any recommendation to prevent this from recurring?

_____

6) Did the employee follow proper safety protocol? _____

7) If no to #6, as you talked to the employee, were any ways to prevent a re-occurrence identified?

_____

_____

Please return the completed form to the Manager of Human Resources.

Signature of Supervisor _____ Date _____

Signature of Employee _____ Date _____