INCIDENT REPORT

(INJURY/OCCUPATIONAL ILLNESS AND/OR ACCIDENT OR NEAR MISS)

Keene State College

INSTRUCTIONS FOR PERSON COMPLETING THIS FORM: Please complete Section 1 of this form for any type of incident. Section 2 must also be completed if there has been an injury. **Section 3 must be completed by a supervisor or appropriate campus official for any incident involving an employee;** and Section 4 must be completed by a supervisor or appropriate campus official for any employee who sought medical attention.

This report must be filed with the KSC Human Resource Management Office within two (2) days of date of incident/injury/illness.

Section 1: This Section must be completed for any type of incident listed below.

Type of Incident: Injury ________ Accident ________ Hazard ________ Near Miss ________

Date of Incident: ________________ Time: ________ Day of Week: ________

Employee: Faculty ________ Staff ________ Complementary ________ Student Worker ________

Other: Student ________ Visitor ________ Contract Employee: ________

Name: ________________ Date of Birth: ________ Male / Female ________

Home Address: ________________________________ Zip Code ________

Home Phone: ________________ Work Phone: ________________

Occupation: ________________ Department: ________________________

Location where incident occurred: ________________________________

Describe the injury, accident, or incident. Include what was being done, how, with what tools and in what conditions. Use drawings or maps and additional sheets if necessary.

Cause of Incident (circle all that apply):

Animal	Electricity	Repetitous movement	Machinery
Insect	Hit by object	Slip or Fall	Tool
Plant	Hot liquid/object	Weather	Sharp object
Chemical	Lifting action	Quality of Air	Needle
Person	Twist	Airborne particle	Fire/Explosion
Criminal Act	Pinch/squeeze	Car accident	Other:___________________

Witness(es) (list witness(es) names(s), address(es), phone numbers and attach statement(s)):

Section 2: This Section must be completed if there has been an injury/illness.

Injured body part (if applicable): ________________________________

Injury type (circle all that apply)

Cut/puncture	Splinter	Body fluid exposure	Fumes/dust/smoke inhalation
Bruise	Heart attack	Electrical shock	Other respiratory
Muscle pull/strain/sprain	Stroke/seizure	Hernia	Vision loss
Bite/scratch	Repetitive stress	Rash/dermatitis	Hearing loss
Broken/fractured bone	Heat exhaustion	Allergic reaction	Death
Amputation	Concussion	Stress	Other: _________________

Did you seek medical treatment? yes / no If yes, where? ________________ Admitted to hospital? yes / no

If yes, and victim is employee, Section 4 must be completed.

Signature of person reporting injury/occupational illness:

________________________________ Date: ________________________________

Section 3: This Section must be completed by supervisor or appropriate campus official any time an incident has been reported.

Was the employee doing something other than his/her required duties at the time of the injury? ______________________

If yes, what, why, and directed by whom? ____

Describe in detail what the employee was doing, how it was being done and tools, people or machines involved. If possible give details such as weights, heights, temperatures, chemicals, etc.

What caused the incident/injury/illness to occur (please circle all that apply)?

Environmental	Personal
Improper or defective equipment	Lack of personal protective equipment
Location (poor layout, poor lighting)	Lack of skill, training or experience
Poor housekeeping (clutter, spillage, breakable objects)	Improper apparel (loose clothing, jewelry, etc.)
Poor ergonomics (lifting, workstation design, inadequate tools)	Bodily conditions (fatigue, physical/mental impairment)
Inadequate safeguards, unsafe job design	Adequate skill but failure to execute and follow direction
Other:_________________________________	Other:____

Describe results of accident investigation (Why did this incident occur and can something be done to avoid a recurrence? If reporting a hazard, suggestions for minimizing or eliminating the hazard):

Section 4: The following information must be completed by supervisor or appropriate campus official if there has been an injury/incident requiring medical attention.

Date of Hire: ________________ Hours worked/Day: ________________ Days worked/Week: ________________

Hourly Rate: $________________ or Annual Rate: $________________ Occupation: ________________

Was the employee given the WC information on approved providers? yes / no Soc. Sec. No.: ________________

Lost time? yes / no If yes, beginning date: ________________

Has injured returned to work? yes / no If yes, date returned: ________________

NOTE: If no lost time as of the date of this report, please send written documentation of lost time when it occurs.

Date injury/illness reported to supervisor or campus official: ______________________________

Name of supervisor or campus official (print): ______________________________

Signature supervisor or campus official: ______________________________

Date: ______________________________