



Incident Report

For EH&S Use Only:	
Incident Report #	_____
<input type="checkbox"/> L&I Claim #	_____
<input type="checkbox"/> Police Report #	_____

-- Required Information: Please Fill Out Form Completely --

Name: <input type="checkbox"/> Female <input type="checkbox"/> Male		Campus / Mail Address:	
Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Office		Email:	Date Of Birth:
Work schedule (Days/times):		Occupation/Job Title:	Date of Incident:
Emp/Student EWU ID:	Injured Party ID:	Injury / Illness Location (select affected area) : <input type="checkbox"/> NA / No Injury <input type="checkbox"/> Abdomen / Internal / etc <input type="checkbox"/> Ankle / Foot /Toes <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Arm / Elbow /Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Ears / Eyes / Nose <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Face / Head <input type="checkbox"/> Hand / Finger / Wrist <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Groin <input type="checkbox"/> Hip / Knee / Leg <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Neck / Throat <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Respiratory	Time of Incident:
Department:			Time Employee Began Work:
Activity Immediately Before Incident:	Employee Type: <input type="checkbox"/> Administrative Exempt <input type="checkbox"/> Faculty <input type="checkbox"/> Classified Staff <input type="checkbox"/> Part Time-Student <input type="checkbox"/> Part Time Non-Student <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Visitor <input type="checkbox"/> Other		Medical Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> First-Aid Only Treatment Date:
			Transportation? <input type="checkbox"/> N/A <input type="checkbox"/> Car/Vehicle <input type="checkbox"/> Walked <input type="checkbox"/> Ambulance
Location of Incident: (Building & room, or description of nearby areas or use physical address when off campus)		SERIOUS INJURY: Notify EH&S ASAP if any of these apply: <input type="checkbox"/> On the job death <input type="checkbox"/> Hospitalization required <input type="checkbox"/> Amputation <input type="checkbox"/> Significant eye injury * If this is a hazardous spill or environmental release, contact EH&S ASAP	Name & Address of Physician or First Aid Administrator:
Name & Address of Hospital:		Name & Address of Hospital:	
Complete Description of Incident: (Attach additional sheets of paper if necessary, including photographs and sketches)		Witnesses: (Include address and phone number if possible, attach additional pages if necessary)	
Prepared By (print):	Prepared By (sign):	Date/Time Reported:	Department:
Chair/Supervisor (Print)	Chair/Supervisor (Sign)	Date Signed:	Supervisor Title:

Supervisors: Use the checklist on page 2 to complete your investigation. Send to Environmental Health & Safety within 24 hours. For serious injuries requiring hospitalization or worker death contact EH&S ASAP, within 8 hours:

Fax: 509-359-4690 or Mail to: 002 Martin Hall / For Questions, Phone: 509-359-6496



Accident Investigation Worksheet

Instructions: The supervisor interviews the injured party and available witnesses (when available) to confirm specifics of the incident, as soon as possible and fill out the questions below. Describe Other, Discuss topics below with employee(s)/ student(s). Document the discussion and corrective action. If a work hazard exists, place a work order at x2245.

Incident Type	Injury Activity							
	Class Event	Campus Recreation	Other		Class Event	Campus Recreation	Other	
<input type="checkbox"/> Abrasion / Scratch	Basketball <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soccer/Rugby <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No Injury <input type="checkbox"/> Assigned Duties <input type="checkbox"/> Driving <input type="checkbox"/> Run/ Walk on Campus <input type="checkbox"/> Other:
<input type="checkbox"/> Bite / Sting	Baseball/Softball <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swimming <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Blood Release	Climbing <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Volleyball <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Bruise / Contusion	Football <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Working Out <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Burn	Hockey/Ice Skating <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Concussion								
<input type="checkbox"/> Crush / Pinch								
<input type="checkbox"/> Cut / Laceration								
<input type="checkbox"/> Dental Injury								
<input type="checkbox"/> Dermatitis								
<input type="checkbox"/> Dislocation								
<input type="checkbox"/> Electric Shock								
<input type="checkbox"/> Eye Injury								
<input type="checkbox"/> Fire								
<input type="checkbox"/> Fracture								
<input type="checkbox"/> Hazardous Contact / Release								
<input type="checkbox"/> Hearing Impairment								
<input type="checkbox"/> Hernia								
<input type="checkbox"/> Illness								
<input type="checkbox"/> Needle Stick / Puncture								
<input type="checkbox"/> Repeated Motion								
<input type="checkbox"/> Sprain / Strain								
<input type="checkbox"/> Other:								
Immediate Cause (What happened to you?)	Root Cause (What is the causal factor?)				Root Cause (What is the causal factor?)			
	<input type="checkbox"/> Animal / Insect <input type="checkbox"/> Athletic / Class Event <input type="checkbox"/> Chemical or Hazardous Material <input type="checkbox"/> Cold / Heat <input type="checkbox"/> Eating <input type="checkbox"/> Electrical Device <input type="checkbox"/> Fall / Slip / Trip <input type="checkbox"/> Fire / Smoke <input type="checkbox"/> Indoor Air Quality <input type="checkbox"/> Lifting <input type="checkbox"/> Medical Condition / Allergic Reaction <input type="checkbox"/> Overexertion <input type="checkbox"/> Power Tool <input type="checkbox"/> Pulling / Pushing <input type="checkbox"/> Repeated Motion <input type="checkbox"/> Sharp Object <input type="checkbox"/> Sitting / Bending <input type="checkbox"/> Struck By <input type="checkbox"/> Twisting <input type="checkbox"/> Vehicle Accident <input type="checkbox"/> Walking / Stepping <input type="checkbox"/> Other:				<input type="checkbox"/> 3 rd Party Action <input type="checkbox"/> Aggravation of Pre-Existing Condition <input type="checkbox"/> Congested Work Area <input type="checkbox"/> Equipment <input type="checkbox"/> Ergonomics <input type="checkbox"/> Failure to Post Warning <input type="checkbox"/> Housekeeping <input type="checkbox"/> Inattention to Activity / Surrounding <input type="checkbox"/> Inadequate Illumination <input type="checkbox"/> Improper Use or No PPE <input type="checkbox"/> Incorrect Procedure <input type="checkbox"/> Infrastructure Problem <input type="checkbox"/> Inherent Risk <input type="checkbox"/> Shortcuts <input type="checkbox"/> Snow / Ice Removal Process <input type="checkbox"/> Training <input type="checkbox"/> Unknown Event / Hazard <input type="checkbox"/> Vision Blocked / Restricted <input type="checkbox"/> Workload <input type="checkbox"/> Other:			
					Factors			
					<input type="checkbox"/> Dark / Light <input type="checkbox"/> Rain <input type="checkbox"/> Dust / Smoke <input type="checkbox"/> Sun / UV <input type="checkbox"/> Fog / Ice / Snow <input type="checkbox"/> Temperature <input type="checkbox"/> Noise <input type="checkbox"/> Water <input type="checkbox"/> Other:			
<p>If you are reporting: Graffiti, Harassment, Theft, or Vandalism – STOP!</p> <p>Call 911 or Contact EWU Campus Police at: 509-359-7676</p>								
<p>What actions (if any) may have prevented the incident (training, safety procedures)?</p>								
<p>Were unsafe conditions or actions responsible for the cause of the accident? If yes, what were they?</p>								
<p>If defective equipment or structural defect (broken stair, missing electrical plate, etc...) was the cause of the accident, was it taken out of service or repaired? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Repaired <input type="checkbox"/> Taken out of Service <input type="checkbox"/> Hazard sign posted/blocked off area <input type="checkbox"/> Work Order Placed Date: _____</p> <p>Describe the Defect(s) & Actions taken:</p>								
<p>Did those affected by the incident receive documented safety training that could have prevented this incident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Training Description:</p> <p>If not, when and what training will be completed?</p>								
<p>Additional Comments:</p>								