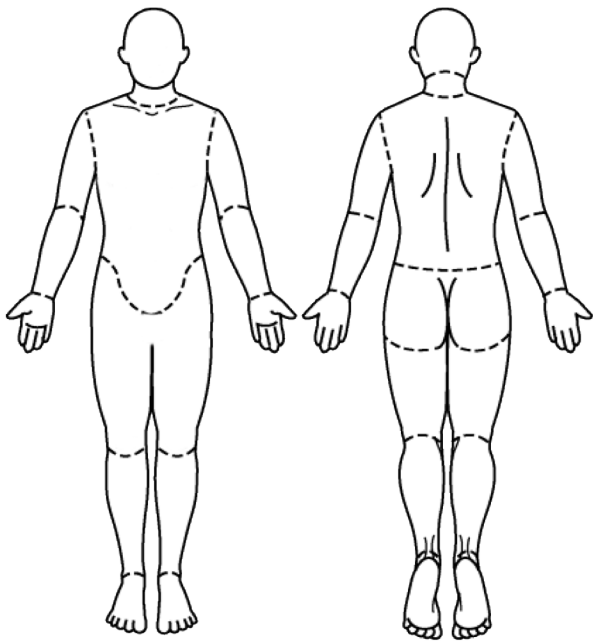


Please complete this form as soon as possible after an incident that results in serious injury or illness occurs.  
(Optional: Use to investigate a minor injury or near miss that could have resulted in a serious injury or illness.)

This is a report of a: ☐ Death ☐ Lost Time ☐ Dr. Visit Only ☐ First Aid Only ☐ Near Miss

Date of Incident: \_\_\_\_\_

### Step 1: Complete this part for each Injured Employee

Injured Employee Name: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age: _____
Department: _____		Job title at time of incident: _____	
<b>Part of body affected:</b> (shade all that apply)  	<b>Nature of injury:</b> (most serious one) <input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system: (e.g. nervous, respiratory or circulatory system)  <input type="checkbox"/> Other: _____	<b>This employee works:</b> <input type="checkbox"/> Regular Full-Time <input type="checkbox"/> Regular Part-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary  <b>Months with this employer:</b> _____  <b>Months doing this job:</b> _____	

### Step 2: Describe the Incident

Address of where the incident occurred: _____		City: _____	State: _____	Zip Code: _____
Exact location of the incident (i.e. specific room): _____		Exact Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<b>What part of employee's workday:</b> <input type="checkbox"/> During meal period	<input type="checkbox"/> Entering or leaving work <input type="checkbox"/> During break	<input type="checkbox"/> Doing normal work activities <input type="checkbox"/> Working overtime	<input type="checkbox"/> Other	
Name of Witness(es) if any: _____				

Please fax completed form to 678-487-8922 or email to [risk@frontlinehro.com](mailto:risk@frontlinehro.com)

<b>Number of attachments:</b>	<b>Written witness statements:</b>	<b>Photographs:</b>	<b>Maps/drawings:</b>
<b>What personal protective equipment was being used (if any)?</b>			
<b>Describe, step-by-step the events that led up to the injury:</b> (Include names of any machines, parts, objects, tools, materials and other important details)			
<div style="text-align: right;"> <input type="checkbox"/> Description continued on attached sheets         </div>			

### Step 3: Why did the incident happen?

<b>Unsafe workplace conditions:</b> (Check all that apply) <input type="checkbox"/> Inadequate guard <input type="checkbox"/> Unguarded hazard <input type="checkbox"/> Safety device is defective <input type="checkbox"/> Tool or equipment defective <input type="checkbox"/> Workstation layout is hazardous <input type="checkbox"/> Unsafe lighting <input type="checkbox"/> Unsafe ventilation <input type="checkbox"/> Lack of needed personal protective equipment <input type="checkbox"/> Lack of appropriate equipment/tools <input type="checkbox"/> Unsafe clothing <input type="checkbox"/> No training or insufficient training <input type="checkbox"/> Other:	<b>Unsafe acts by people:</b> (Check all that apply) <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Servicing equipment that has power to it <input type="checkbox"/> Making a safety device inoperative <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting by hand <input type="checkbox"/> Taking an unsafe position or posture <input type="checkbox"/> Distraction, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment/tools <input type="checkbox"/> Other:
<b>Why did the unsafe conditions exist?</b>	
<b>Why did the unsafe acts occur?</b>	
<b>Was there a basis (such as “the job can be done more quickly” or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If yes, describe:</b>	
<b>Were the unsafe acts or conditions reported prior to the incident?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Have there been similar incidents or near misses prior to this one?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Step 4: How can future incidents be prevented?

### What changes:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Stop this activity               | <input type="checkbox"/> Guard the hazard              | <input type="checkbox"/> Train the employee(s)   | <input type="checkbox"/> Train the supervisor(s) |
| <input type="checkbox"/> Redesign task steps              | <input type="checkbox"/> Redesign work station         | <input type="checkbox"/> Write a new policy/rule | <input type="checkbox"/> Enforce existing policy |
| <input type="checkbox"/> Routinely inspect for the hazard | <input type="checkbox"/> Personal Protective Equipment | <input type="checkbox"/> Other: _____            |  |

### What should be (or has been) done to carry out the suggestion(s) checked above?

☐ Description continued on attached sheets

## Step 5: Who completed and reviewed this form? (Please Print)

Written by:

Title:

Department:

Date:

Names of investigation team members:

☐ Description continued on attached sheets

Reviewed by:

Title:

Date: