

Incident and Injury Report

To be completed by the injured employee

Claim number _____

Name	Hire date	Age	Sex
Street	City	State	Phone
Describe your injury			
Describe, in detail, what you were doing and what happened when the incident occurred. (Attach additional sheets if needed.)			
Employee signature			Date

To be completed by supervisor, manager, safety professional, etc.

Time and date of incident	Date reported	Injured employee's job title	Years of job experience																
Injury source <input type="checkbox"/> Animal bite/scratch <input type="checkbox"/> Burn <input type="checkbox"/> Caught in/between <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Cut or laceration <input type="checkbox"/> Manual material handling <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Slip, trip, fall <input type="checkbox"/> Struck by or against <input type="checkbox"/> Workplace violence <input type="checkbox"/> Other:	Body part(s) affected <input type="checkbox"/> Head <input type="checkbox"/> Eye(s) <input type="checkbox"/> Ear(s) <input type="checkbox"/> Back/neck <input type="checkbox"/> Arm/shoulder <input type="checkbox"/> Hand/finger <input type="checkbox"/> Chest/torso <input type="checkbox"/> Leg/knee/ankle/foot <input type="checkbox"/> Lung(s)	Relevant training received <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Subject</th> <th style="width: 30%;">Date</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Subject	Date														
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Location of incident	Nature of injury	PPE required	Used																
Type of incident <input type="checkbox"/> First Aid <input type="checkbox"/> Medical treatment <input type="checkbox"/> Lost work day(s) <input type="checkbox"/> Fatality <input type="checkbox"/> Near-miss	Witnesses		<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Yes</th> <th style="width: 50%;">No</th> </tr> </thead> <tbody> <tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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Email: claims@atlanticpayroll.us

Fax: 772-466-0410

If you have any questions, please call us at 772-466-0440

Accident Analysis

To be completed by supervisor, manager, safety professional, etc.

Describe the incident, in detail, as determined by investigation. (Attach additional sheets, if needed.)

Root cause analysis

1. Identify all contributing factors.
2. For each, ask "Would the incident have happened if this particular factor was not present?"
If the answer is "No," then it is a root cause (RC).
3. For nearly every incident, there are multiple root causes/contributing factors

Yes = CF
No = RC

Manpower	CF	RC	Material	CF	RC	Management systems	CF	RC
Failure to follow procedure/rule			Defective tool/equipment			Not properly trained		
Failure to use proper PPE			Improperly guarded equipment			Poor housekeeping		
Improper use of tool/equipment			Not properly trained			No/poor procedure		
Horseplay			Poor lighting			Ineffective communication		
Distracted/breakdown of awareness			Poor ventilation			No/poor job planning		
Fatigue/stress/frustration			Environmental (weather, temp, animal)			Heavy workload/tight schedule (real or perceived)		
			Poor design/layout			Long/unusual work hours		

Corrective actions

Action	Due date	Person/department responsible

Supervisor

Date

Manager

Date

Safety professional

Date



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Photo Sheet

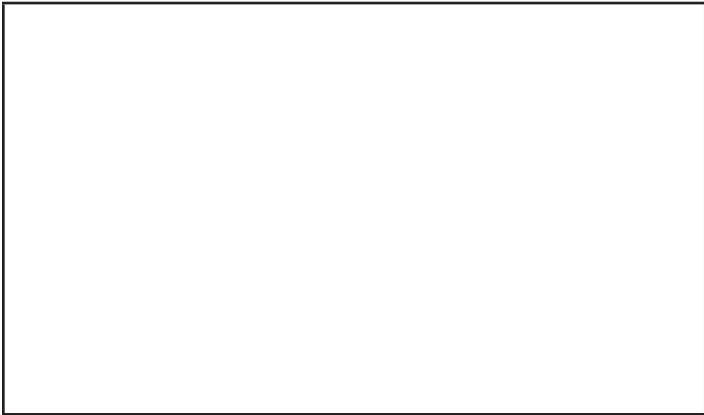


Photo 1: Description

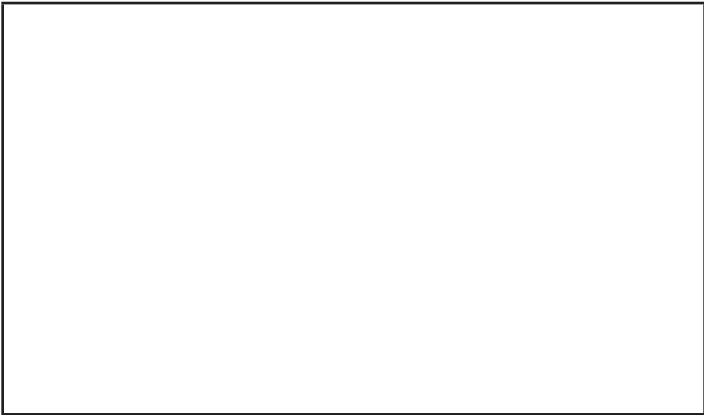


Photo 2: Description

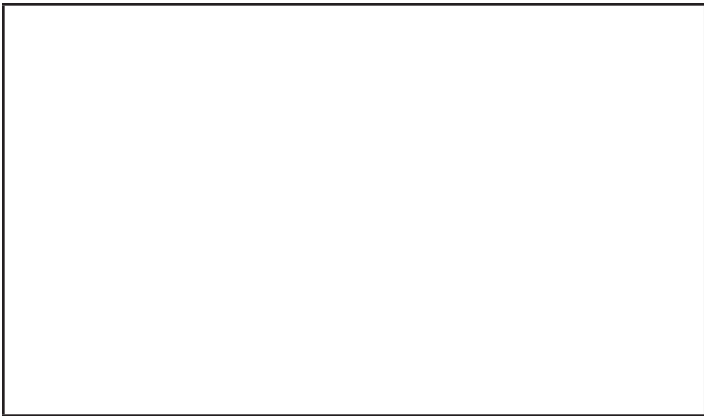


Photo 3: Description

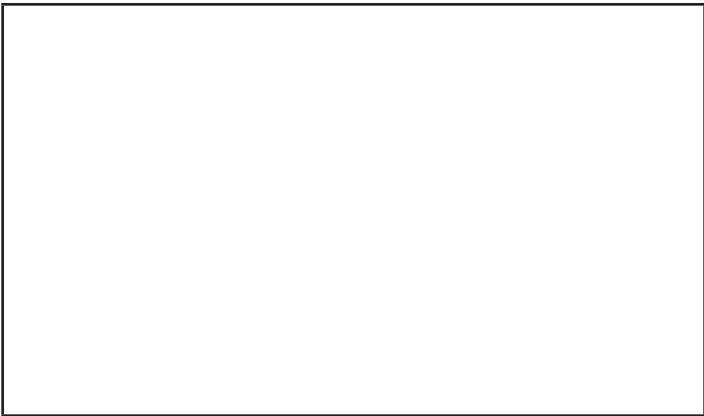


Photo 4: Description



Photo 5: Description



Photo 6: Description



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Incident Witness Statement

Name of injured employee	Date of Incident
Name of witness	Date of statement

Were you in the area when the incident occurred?

Yes No

Did you see the incident happen?

Yes No

If "Yes" to either of the above, describe what you observed in detail.

How can a similar incident be prevented in the future?

Was an injury reported as a result of the incident?

Yes No

Have you ever heard the injured employee ever complain of a similar injury or illness?

Yes No

Are you aware of any previous injuries/incidents, on or off the job, that the employee has had?

Yes No

If so, describe.

I affirm that the above information is complete and accurate to the best of my knowledge.

Witness signature

Date



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