



ACCIDENT/INJURY REPORT

This form is to be used to report workplace accidents, to include: near misses, injuries, illnesses, or exposures. Use ballpoint pen and attach additional sheets to this report if more room is needed. The individual will complete Part I of this report. The supervisor or instructor will conduct a thorough review and complete Part II. The Safety Officer will investigate the event, identify a primary cause if possible, add any written recommendations, make copies, and distribute the form when completed.

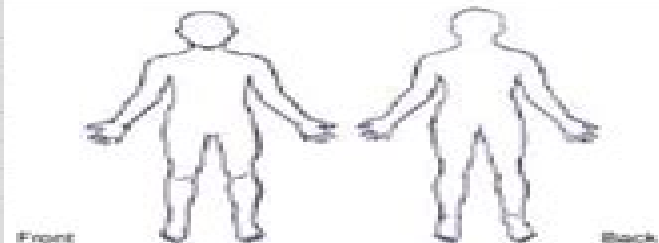
Do not move equipment involved in a work-related accident involving a fatality, hospitalization of 2 or more staff, or serious injury unless moving the equipment 1) allows victims to be removed or 2) prevents further accidents. The equipment **must not** be moved until a representative of the Department of Labor & Industries investigates the accident and releases the equipment.

PART I – TO BE COMPLETED Within 24 hours

1. Employee Use Electronic Form Contract staff Use Electronic Form <input type="checkbox"/> Volunteer <input type="checkbox"/> Visitor		<input type="checkbox"/> Class II Correctional Industries <input type="checkbox"/> Class IV Off Site Work Crew <input type="checkbox"/> Class III Institutional Support <input type="checkbox"/> Class V Community/Restitution Worker		Offender Number
2. Individual Name (Last, First, MI)		3. Sex <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of birth	5. Work telephone #
6. Job Classification/Working Title		7. Normal scheduled shift <input type="checkbox"/> Day <input type="checkbox"/> Afternoon <input type="checkbox"/> Night		8. Days off
9. Assigned Work Location			10. Address/Mail Stop	
11. Location of incident, Facility, Building – Be General, i.e., (example) West Complex Food Service Back Door.			12. Date of event:	13. Time of event <input type="checkbox"/> AM <input type="checkbox"/> PM
14. What part(s) of body was affected (e.g., right ankle, left index finger, lungs, etc.)?				

15. Type of Injury/Illness/Exposure (check all that apply)

<input type="checkbox"/> Ache/Soreness	<input type="checkbox"/> Burn-Steam	<input type="checkbox"/> Body Fluids or Blood of Another Person
<input type="checkbox"/> Noise	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fumes/Gas/Vapors
<input type="checkbox"/> Contact with Toxics/Chemicals	<input type="checkbox"/> Disease-Infection	<input type="checkbox"/> Wound/Abrasion
<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Tingling/Numbness	<input type="checkbox"/> Nausea
<input type="checkbox"/> Burn-Chemical	<input type="checkbox"/> Contusion/Blueses	
<input type="checkbox"/> Burn-Flame	<input type="checkbox"/> No Injury/Illness	<input type="checkbox"/> Other
<input type="checkbox"/> Needle Stick(Add type and brand name of needle/syringe in # 16 below)		



16. How did you sustain a work injury? _____	
17. What have you done or are going to do to ensure accidents/incidents of this type do not happen in the future? _____	
18. Did this incident occur during training? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Do you believe you were assaulted by an offender? (per DOC 830.180 Assault Benefits for Employees) <input type="checkbox"/> Yes <input type="checkbox"/> No
20. Was this a work related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Was this an aggravation of a previous injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
22. To whom did you report this event?	23. Name of witness, their title, and work telephone number

Signature _____

Date _____

Kanas Workers Accident Report Forms

Lingsheng Yao



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