**INCIDENT/NEAR MISS REPORT**

***(Check one):***

\_\_\_An incident is an event that caused injury to a person or damage to equipment, building or materials.

\_\_\_A near miss is an event that could have caused injury to a person or damage to equipment, building or materials.

Person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and job title of the employee involved in the incident/near miss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness(es):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of incident/near miss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time of incident/near miss: \_\_\_\_\_\_\_a.m./p.m.

Department and location where the incident/near miss occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s shift on the day of the incident/near miss (from) \_\_\_\_\_\_\_\_\_\_\_\_\_ a.m./p.m. (to) \_\_\_\_\_\_\_\_\_\_\_\_\_ a.m./p.m.

Did an injury occur? \_\_\_\_\_ Yes \_\_\_\_\_ No

Nature of the injury (strain, cut, bruise, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body part(s) affected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical treatment required? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, what type? \_\_\_\_\_ First aid on-site \_\_\_\_\_ Express care \_\_\_\_\_ Doctor \_\_\_\_\_ Hospital

Name of the facility, hospital or physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the employee hospitalized overnight as a patient? \_\_\_\_\_ Yes \_\_\_\_\_ No

Did the employee leave work early due to the injury? \_\_\_\_\_ Yes \_\_\_\_\_ No   
If yes, what time? \_\_\_\_\_\_\_\_\_\_ a.m./p.m.

Date the employee returned to regular duty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date the employee returned with light duty restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the incident fully: (use back page if necessary or sketch on back if needed to clarify):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all equipment, machinery, materials or chemicals the employee was using when the event occurred:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Identify the factors that you believe contributed to or caused the incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Complete this section if an injury occurred or there was damage to equipment.***

Were proper procedures being followed when the incident occurred? \_\_\_\_ Yes \_\_\_\_ No

If no explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the employee wearing proper personal protective equipment? \_\_\_\_ N/A \_\_\_\_ Yes \_\_\_\_ No

If no explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are changes in equipment necessary to prevent reoccurrence? \_\_\_\_ Yes \_\_\_\_ No

If yes explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forward this form to the Human Resources Department as soon as possible following the incident or near miss.

Note: If an employee receives medical treatment from a doctor or hospital, additional forms will need to be filled out and forwarded to the HR Dept. along with the incident report so a workers’ compensation claimed can be filed.