INCIDENT REPORT FORM

Person(s) Involved in Accident:________________________ Phone:____________

Witnesses:________________________ Phone:____________

Supervisor:________________________ Phone:____________

Building:________________________ Room Number:____________

Department:________________________ Date of Incident:____________

Supervisor or person involved in accident: Please complete the following sections in as much detail as possible and return to the EH&S office within 7 working days. Retain a copy for your records.

DESCRIBE INCIDENT DETAILS (activity being conducted, what happened, where, etc.):

ANALYSIS OF INCIDENT (include your opinion on the cause, why it happened, how ,etc.):

DESCRIBE CORRECTIVE ACTIONS TAKEN TO PREVENT REOCCURANCE
(equipment replaced, procedure modified, follow up employee training, etc.):

OTHER DETAILS

Was anyone injured because of this incident? YES NO If yes, what part of the body was affected?____________

If injured, did the person receive medical aid? Cowell Student Health Center Dominicon Hospital On site first aid
Refused Treatment Other:____________

Was Personal Protective Equipment (PPE) being worn? YES NO Not Applicable
If yes, what PPE was being worn? gloves glasses lab coat Other:____________

Had the person been trained in appropriate safety precautions and protocols? YES NO
Date of documented training:____________

________________________ ____________
Supervisors Signature Date