

**COMMUNITY ACTION OF ORLEANS & GENESEE
INCIDENT REPORT FORM
INSTRUCTIONS**

Any incident must be reported to your supervisor immediately. Refer to Community Action's Safety Manual, Accident Reporting Section for a detailed definition of an incident / accident.

The injured person should complete the Employee's Report of Injury Form, if possible. If not, the supervisor should complete the form. This is to be signed and dated by the person filling out the form. Give the completed form to your supervisor.

The supervisor then completes their portion of the Report. Make sure all information is completed, including the date and time you had knowledge of the incident. If you have questions or need assistance with completing the form, contact the Fiscal Office. Forward the original to the Program Director.

The Incident Investigation Form is to be completed as soon as possible after an incident that results in serious injury or illness.

The Program Director reviews report, initialing the original and sending it to the Fiscal Department.

When completing the form please be sure to include any information you think will be helpful to the Fiscal Office or the insurance company, including any possible follow up. If necessary, attach additional pages.

If there are questions, call Susan Jessmer in the HR Office, 585-589-5605 ext. 104.

REMEMBER:

The incident report must be completed and submitted to the Fiscal Office within 24 hours of the date/time of the accident.

Perforated part is for the employee to give to the Doctor or Hospital, etc.

WORKERS COMPENSATION INJURY

**Genesee County
Orleans County**

**Workfit Medical Center
178 Washington Avenue
Batavia**

585-343-0334

**Hours: Monday thru Friday–
8:30am to 4:00pm**

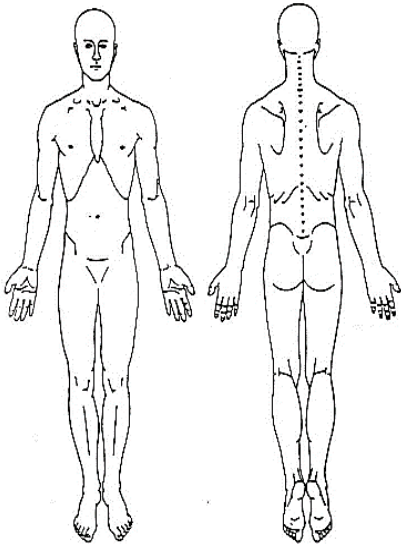
**BILL GOES TO:
EMPLOYER:**
Community Action of Orleans &
Genesee
409 East State Street
Albion, NY 14411

CONTACT:
Susan Jessmer
HR and Payroll
Administrator
585-589-5605

REMIT BILL TO:
Employer – Atten: Susan

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work-related injuries, illnesses, or “near miss” events (which could have caused an injury or illness). This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action. The intention of the Near Miss report is to educate and share information across locations to prevent the occurrence of future accidents. It is not intended to be punitive and employee personal information is not shared.

I am reporting a work related: <input type="radio"/> Injury <input type="radio"/> Illness <input type="radio"/> Near miss	
Your Name:	Phone:
Job title:	Home Address:
Supervisor:	City: State: Zip:
Who did you notify about this injury/near miss?	
Date of injury/near miss: Time of injury/near miss:	Location of injury/near miss:
Was first aid offered? <input type="radio"/> Yes <input type="radio"/> No If yes, what type was given, and by whom? Was there a blood-borne pathogen exposure/needle stick? <input type="radio"/> Yes <input type="radio"/> No	
Names of witnesses:	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? (Indicate on diagram) If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? <input type="radio"/> Yes <input type="radio"/> No	
If yes, whom did you see? Doctor's phone number:	Date and time of doctor visit:
Has this part of your body been injured before? <input type="radio"/> Yes <input type="radio"/> No If yes, when?	
Your signature:	Date:
For Supervisor: Review the employee's report and fill out the following boxes. By signing this document, you are validating that you have reviewed the employee's report and verify the information given is accurate. For any additional information attach another page to this form; for serious injuries, an Incident Investigation form that can be found at: http://www.caoginc.org/wp-content/uploads/Incident_Investigation_Form.pdf	
Was the Employee sent for a drug test? <input type="radio"/> Yes <input type="radio"/> No	Was there disciplinary action taken? <input type="radio"/> Yes <input type="radio"/> No If yes, what?
Supervisor's signature:	Date:

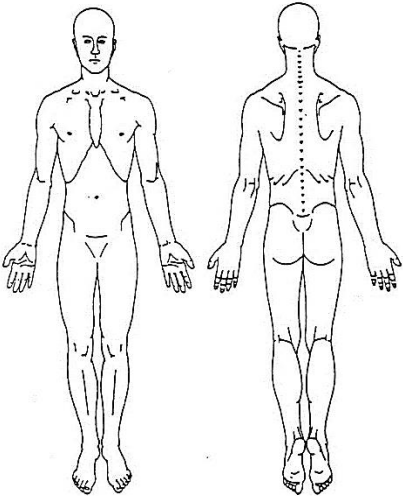
Incident Investigation Report

Instructions: Complete this form as soon as possible after an incident that results in serious injury or illness.
 (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: <input type="radio"/> Death <input type="radio"/> Lost Time <input type="radio"/> Dr. Visit Only <input type="radio"/> First Aid Only <input type="radio"/> Near Miss
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Date of incident:	This report is made by: <input type="radio"/> Employee <input type="radio"/> Supervisor <input type="radio"/> Team <input type="radio"/> Other _____
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Step 1: Injured employee (complete this part for each injured employee)

Name:	Department:						
Part of body affected: (shade all that apply)	Job title at time of incident:						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;"> Nature of injury: (most serious one) <input type="radio"/> Abrasion, scrapes <input type="radio"/> Amputation <input type="radio"/> Broken bone <input type="radio"/> Bruise <input type="radio"/> Burn (heat) <input type="radio"/> Burn (chemical) <input type="radio"/> Concussion (to the head) <input type="radio"/> Crushing Injury <input type="radio"/> Cut, laceration, puncture <input type="radio"/> Hernia <input type="radio"/> Illness <input type="radio"/> Sprain, strain <input type="radio"/> Damage to a body system: <input type="radio"/> Other _____ </td> <td style="width: 40%; padding: 5px;"> This employee works: <input type="radio"/> Regular full time <input type="radio"/> Regular part time <input type="radio"/> Temporary <input type="radio"/> Volunteer <input type="radio"/> Client <input type="radio"/> Other: _____ </td> </tr> <tr> <td colspan="2" style="padding: 5px;">Months with this employer:</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Months doing this job:</td> </tr> </table>	Nature of injury: (most serious one) <input type="radio"/> Abrasion, scrapes <input type="radio"/> Amputation <input type="radio"/> Broken bone <input type="radio"/> Bruise <input type="radio"/> Burn (heat) <input type="radio"/> Burn (chemical) <input type="radio"/> Concussion (to the head) <input type="radio"/> Crushing Injury <input type="radio"/> Cut, laceration, puncture <input type="radio"/> Hernia <input type="radio"/> Illness <input type="radio"/> Sprain, strain <input type="radio"/> Damage to a body system: <input type="radio"/> Other _____	This employee works: <input type="radio"/> Regular full time <input type="radio"/> Regular part time <input type="radio"/> Temporary <input type="radio"/> Volunteer <input type="radio"/> Client <input type="radio"/> Other: _____	Months with this employer:		Months doing this job:	
Nature of injury: (most serious one) <input type="radio"/> Abrasion, scrapes <input type="radio"/> Amputation <input type="radio"/> Broken bone <input type="radio"/> Bruise <input type="radio"/> Burn (heat) <input type="radio"/> Burn (chemical) <input type="radio"/> Concussion (to the head) <input type="radio"/> Crushing Injury <input type="radio"/> Cut, laceration, puncture <input type="radio"/> Hernia <input type="radio"/> Illness <input type="radio"/> Sprain, strain <input type="radio"/> Damage to a body system: <input type="radio"/> Other _____	This employee works: <input type="radio"/> Regular full time <input type="radio"/> Regular part time <input type="radio"/> Temporary <input type="radio"/> Volunteer <input type="radio"/> Client <input type="radio"/> Other: _____						
Months with this employer:							
Months doing this job:							

Step 2: Describe the incident

Exact location of the incident:	Exact time:
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What part of employee's workday? Entering or leaving work Doing normal work activities
 During meal period During break Working overtime
 Other _____

Names of witnesses (if any):

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

Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply) <ul style="list-style-type: none"> <input type="radio"/> Inadequate guard <input type="radio"/> Unguarded hazard <input type="radio"/> Safety device is defective <input type="radio"/> Tool or equipment defective <input type="radio"/> Workstation layout is hazardous <input type="radio"/> Unsafe lighting <input type="radio"/> Unsafe ventilation <input type="radio"/> Lack of needed personal protective equipment <input type="radio"/> Lack of appropriate equipment / tools <input type="radio"/> Unsafe clothing <input type="radio"/> No training or insufficient training <input type="radio"/> Other: _____ 	Unsafe acts by people: (Check all that apply) <ul style="list-style-type: none"> <input type="radio"/> Operating without permission <input type="radio"/> Operating at unsafe speed <input type="radio"/> Servicing equipment that has power to it <input type="radio"/> Making a safety device inoperative <input type="radio"/> Using defective equipment <input type="radio"/> Using equipment in an unapproved way <input type="radio"/> Unsafe lifting <input type="radio"/> Taking an unsafe position or posture <input type="radio"/> Distraction, teasing, horseplay <input type="radio"/> Failure to wear personal protective equipment <input type="radio"/> Failure to use the available equipment / tools <input type="radio"/> Other: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Is there a reward (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? <input type="radio"/> Yes <input type="radio"/> No If yes, describe:	
Were the unsafe acts or conditions reported prior to the incident? <input type="radio"/> Yes <input type="radio"/> No	
Have there been similar incidents or near misses prior to this one? <input type="radio"/> Yes <input type="radio"/> No	

Step 4: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

- Stop this activity Guard the hazard Train the employee(s) Train the supervisor(s)
- Redesign task steps Redesign work station Write a new policy/rule Enforce existing policy
- Routinely inspect for the hazard Personal Protective Equipment 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:	
Reviewed by:	Title:
	Date:
Director's Signature:	Date: