

Calvin College Incident Report Form

Check the box(es) to indicate what you are reporting:

☐ Injury
 ☐ Incident
 ☐ Property/Equipment Damage
 ☐ Near Hit/Close Call

Are you a...

☐ Student Worker
 ☐ Faculty
 ☐ Staff
 ☐ Non-Employee

| INJURED PARTY | | | | | |
|--|---------------|--|--------------------|--|--|
| Employee Name | Job Title | Dept | | Shift <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd | |
| Home Address | | | City | | State / Zip |
| Home Phone Number | Date of Birth | Date of Hire | Date of Occurrence | Time of Occurrence | Social Security # (must have for filing comp claim) |
| Name of Witness(es) | | Where did incident occur? (i.e., loading dock at north entrance of SB) | | | Date Reported to EHS or Supervisor |
| Nature of injury: <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Fracture <input type="checkbox"/> Laceration <input type="checkbox"/> Bruising <input type="checkbox"/> Scratch/Abrasion <input type="checkbox"/> Dislocation <input type="checkbox"/> Amputation <input type="checkbox"/> Burn/Scald <input type="checkbox"/> Foreign Body <input type="checkbox"/> Chemical Reaction <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Concussion <input type="checkbox"/> Heat Related Illness <input type="checkbox"/> Other (specify): Click here to enter text. | | | | | |
| Previous injury to affected body part? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If YES, explain in detail | | | |

| PROPERTY and/or EQUIPMENT DAMAGE | |
|--|--|
| List property / equipment damaged: Click here to enter text. | Nature of damage: Click here to enter text. |
| Object / substance inflicting the damage: Click here to enter text. | Approximate cost: Click here to enter text. |

| THE INCIDENT |
|--|
| Who was involved in the incident? Click here to enter text. |
| What were you doing when the incident occurred? Click here to enter text. |
| What do you believe caused the incident to occur? Click here to enter text. |
| What could be done to prevent this incident from happening again? Click here to enter text. |
| If you were using equipment/tools, were guards, safety devices, and/or interlocks active or in use? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If a contractor was involved, please provide name and address: Click here to enter text. |

| WHY did this happen? (Root Cause Analysis) Check all that apply | | |
|---|--|---|
| UNSAFE ACTS | UNSAFE CONDITIONS | MANAGEMENT SYSTEM DEFICIENCIES |
| <input type="checkbox"/> Improper work technique | <input type="checkbox"/> Poor workstation design or layout | <input type="checkbox"/> Lack of written procedures or safety rules |
| <input type="checkbox"/> Improper PPE, not used or used incorrectly | <input type="checkbox"/> Fire or explosion hazard | <input type="checkbox"/> Safety rules not enforced |
| <input type="checkbox"/> Safety rule violation | <input type="checkbox"/> Congested work area | <input type="checkbox"/> Hazards not identified |
| <input type="checkbox"/> Operating without authorization | <input type="checkbox"/> Hazardous substances | <input type="checkbox"/> PPE unavailable |
| <input type="checkbox"/> Failure to secure or warn others | <input type="checkbox"/> Inadequate ventilation | <input type="checkbox"/> Insufficient worker training |
| <input type="checkbox"/> Operating at improper speeds | <input type="checkbox"/> Improper material storage | <input type="checkbox"/> Insufficient supervisor training |
| <input type="checkbox"/> By-passing safety devices | <input type="checkbox"/> Improper tool or equipment | <input type="checkbox"/> Improper maintenance |
| <input type="checkbox"/> Guards not used | <input type="checkbox"/> Insufficient job knowledge | <input type="checkbox"/> Inadequate supervision |
| <input type="checkbox"/> Improper loading or placement | <input type="checkbox"/> Slippery conditions | <input type="checkbox"/> Insufficient job planning |
| <input type="checkbox"/> Improper lifting | <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Inadequate hiring practices |
| <input type="checkbox"/> Servicing or adjusting machinery in motion | <input type="checkbox"/> Excessive noise | <input type="checkbox"/> Poor process design |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Inadequate guarding of hazards | <input type="checkbox"/> Inadequate workplace inspections |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Defective tools/equipment | <input type="checkbox"/> Inadequate equipment |
| <input type="checkbox"/> Unsafe act of others | <input type="checkbox"/> Insufficient lighting | <input type="checkbox"/> Unsafe design or construction |
| <input type="checkbox"/> Unnecessary haste | <input type="checkbox"/> Inadequate fall protection | <input type="checkbox"/> Unrealistic scheduling |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |
| List immediate action taken: Click here to enter text. | | |
| What should be done to prevent a recurrence: Click here to enter text. | | |

| SIGNATURES | |
|-------------------------------------|-------|
| Employee or Non-employee signature: | Date: |
| Supervisor signature: | Date: |