AUGUSTANA COLLEGE
INCIDENT REPORT

INJURY ☐
ILLNESS ☐
NEAR MISS ☐

CLAIM#_____(ASSIGNED BY TRAVELER'S INSURANCE)

This form should be used to report incidents involving work related injuries or illness for all employees of the college. Please complete every space, or mark it "NA" if not applicable. The college is required to track this information and report it to the government (OSHA).

EMPLOYEE NAME: _____ ☐ Male ☐ Female	**SOCIAL SECURITY NUMBER** _____	**DATE OF BIRTH:** **DATE OF HIRE:** **WAGE:**
JOB TITLE	**DEPARTMENT**	**SUPERVISOR**
HOME PHONE #	**WORK PHONE** #	**DOES THIS EMPLOYEE WORK FOR OTHER DEPARTMENTS ON CAMPUS?** ☐ YES ☐ NO
DATE OF INJURY: ____/____/____ **DATE REPORTED:** ____/____/____ **REPORTED TO:**_____	**TIME EMPLOYEE BEGAN SHIFT:** _____AM/PM (CIRLE ONE) **TIME OF INJURY**: _____AM/PM (CIRCLE ONE)	**EVENT OCCURRED:** ☐ BEFORE ☐ DURING ☐ AFTER SCHEDULED WORK SHIFT

ACCIDENT RESULTED IN (CHECK ALL THAT APPLY):

☐ ON SITE FIRST AID	☐ CLINIC VISIT	☐ RESTRICTED DUTY	☐ AFFECTED HEARING
☐ ILLNESS	☐ EMERGENCY ROOM	☐ LOST TIME	☐ SKIN DISORDER
☐ NO INJURY/ILLNESS	☐ HOSPITALIZATION	☐ CHEMICAL EXPOSURE	☐ RESPIRATORY CONDITION
☐ PROPERTY DAMAGE	☐ AMBULANCE	☐ UNCONSCIOUSNESS FOR ANY LENGTH OF TIME	

COMPLETE HOME ADDRESS (STREET, CITY, STATE, and ZIP)

INCIDENT DESCRIPTION (DESCRIBE WHAT THE EMPLOYEE WAS DOING, THE INCIDENT, AND DETAILS ABOUT CHEMICAL EXPOSURE, IF ANY)

NATURE OF INJURY (SCRATCH, CUT, BRUISE, ETC.)	**LOCATION OF INCIDENT** (EX. OLD MAIN ROOM 115, CORRIDOR ON 2ND FLOOR OF SCIENCE BLDG, WESTERLIN PARKING LOT)
PART OF BODY INJURED (LEFT RING FINGER, RIGHT ANKLE, ETC.)	**WITNESSED BY** (NAME AND CONTACT INFORMATION)

FACTORS: WHAT CONDITIONS, EQUIPMENT, SUBSTANCE OR OBJECT CONTRIBUTED TO THE INCIDENT? (EX. OIL ON FLOOR, BROKEN MACHINE GUARD, DID NOT LOCK OUT MACHINE, NOT WEARING SAFETY GLASSES, OLD WOODEN LADDER)

MEDICAL CARE PROVIDED – DATE OF SERVICE:_____ **BY:**

☐ Concentra – 555 Valley View Dr. Moline, IL 61265 (309) 764-9675 ☐ OTHER:

WAS EMPLOYEE HOSPITALIZED OVERNIGHT? **WHERE**? ☐YES ☐NO	**LAST DATE EMPLOYEE WORKED**

HOW CAN WE PREVENT THIS FROM HAPPENING AGAIN TO THIS PERSON OR OTHERS AT THE COLLEGE?

EMPLOYEE RESPONSIBLE FOR CORRECTIVE ACTION

NAME: **TITLE:** **DATE:**

EMPLOYEE STATEMENT

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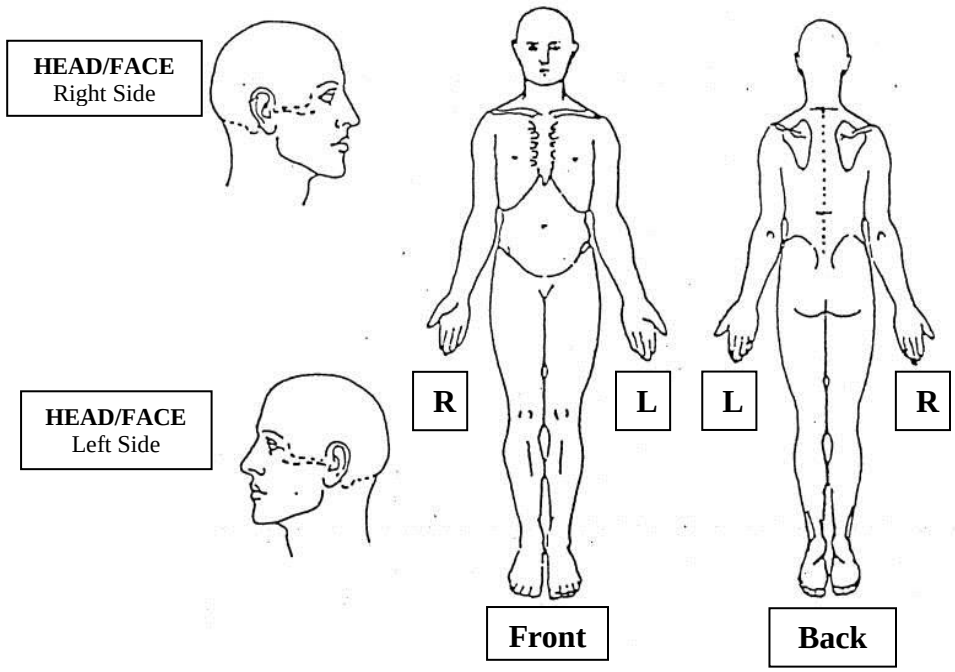
PLEASE CIRCLE ALL INJURED BODY PARTS AS A RESULT OF THIS INCIDENT



EMPLOYEE SIGNATURE:_____ **DATE:**_____