 **Accident Report Form** Questions?

***Must be filled out and submitted within two days of accident*** Contact Administrative

***or discovery of an occupational illness*** Services at 509.682.6514

**Use this form to report workplace injury accidents, an occupational illness or any other accident to an employee, student or visitor that involves an injury on the WVC campus OR to an employee or student off campus during working status.** Provide detailed information and complete the form as accurately as possible. Submit the completed and signed form to the department supervisor for review and signature. Signatures are required on this form prior to being submitted, unless the affected party is unable to sign at the time of the accident, then follow up will take place at a later date.  **The accident form must be submitted directly to Heather Maddy, Administrative Services, Third Floor, Wenatchi Hall.**

|  |
| --- |
| **Person Affected by Workplace Injury, Accident or Report of Occupational Illness** |
| Name (please print):       | Phone:       | Email:       |
| Address:       |
| Date of Birth:       Hire Date:       Gender: [ ]  Male [ ]  Female |
| Type: [ ]  Employee [ ]  Student Employee [ ]  Student [ ]  Volunteer [ ]  Visitor [ ]  Other:       |
| **Injury/Accident/Illness Details** |
| Date of Injury or Illness:       | Time of Event::       [ ]  AM [ ]  PM |
| Time Employee Began Work:       [ ]  AM [ ]  PM |
| Accident Location (building/room/parking lot - be specific):       |
| Condition of Accident Site (wet, dry, icy, dark, other):       |
| **Clearly describe what happened (e.g., cut to left hand index finger while using a hand grinder) and circle the injury location(s) on the figures below. Use the back of form if needed.** |
|       |  |
| **Medical Treatment/Assistance (check all that apply)** |
|  [ ]  None Required [ ]  First Aid (returned to class/work) [ ]  First Aid (sent home) [ ]  Private Physician [ ]  Emergency Room [ ]  Medical/Dental (including clinic/hospital outpatient treatment) [ ]  Hospitalized (admitted as inpatient) [ ]  Other:       |
| Who provided treatment (list name of provider, clinic/hospital)?       |
| **Person Reporting Accident (if different than person affected)** |
| Name:       | Phone:       | Email:       |
| Address:       | Date Reported:       | Time Reported:       [ ]  AM [ ]  PM |
| **Witnesses (attach statement for each)** |
| Name:       | Phone:       | Email:       |
| Name:       | Phone:       | Email:       |

|  |
| --- |
| **Possible Causes** |
| **Equipment** | **Environment** | **Policies/Procedures** | **Human Factors** |
| [ ]  Defective Tools/Equipment[ ]  Defective Material[ ]  No Guards/Barriers[ ]  Inadequate Guards/Barriers [ ]  Using Equipment Improperly[ ]  Inadequate Maintenance[ ]  Improper Personal Protective Equipment (PPE)[ ]  Lack of PPE[ ]  Other (explain)      \_\_ | [ ]  Inadequate [ ]  Poor Housekeeping Ventilation [ ]  Inclement Weather[ ]  Inadequate [ ]  Slippery/Uneven or Excessive surface Illumination [ ]  Ergonomics Issues[ ]  Air Contaminants [ ]  Sharp Objects[ ]  Chemicals [ ]  Hot Objects[ ]  Noise [ ]  Hot weather conditions[ ]  Fire [ ]  Cold weather cond.[ ]  Explosion [ ]  Animal Action[ ]  Other (explain)      \_\_ | [ ]  Failure to Follow Procedures[ ]  Appropriate Procedures Non-existent[ ]  Inadequate Instructions/ Procedures[ ]  Inadequate Planning/ Preparation[ ]  Inadequate Support/ Assistance[ ]  Other (explain)      \_\_ | [ ]  Inadequate Training [ ]  Verbal Assault[ ]  Inadequate/ Improper [ ]  Physical Assault Protocols/Procedures/ [ ]  Inattention Expectations/PPE [ ]  Loss of Balance[ ]  PPE Not Used [ ]  Rushing[ ]  Improper Lifting [ ]  Phobia/Anxiety[ ]  Failure to Follow [ ]  Horseplay Established Protocols/ [ ]  Other  Procedures (explain)      \_\_ |
| **Suggested Corrective Actions by the Affected Party** |
| [ ]  Provide safety training [ ]  Change/review work procedures [ ]  Submit work order for maintenance/repair[ ]  Undertake hazard assessment [ ]  Provide protocols, procedures and expectations [ ]  Change work area layout/design |
| As you are the affected party, what actions could you have taken to prevent the injury from occurring?      |
| **Signature(s)** |
| Signature of Affected Party Date       | Signature of Person Reporting Accident Date       |

**The following sections to be filled out by WVC management**

|  |
| --- |
| **Supervisor Comments and Signature** |
| Possible Cause(s):(As the supervisor, please identify one or more of the factor(s) that may have contributed to the accident, including equipment, policies, procedures and/or personnel.)      |
| As the supervisor, please identify the recommendation(s)/preventive measure(s)—Identify at least one:      |
| Name and Title (please print):      | Signature: | Date:      |
| **Safety Officer Comments and Signature** |
| Possible Cause(s):(Please consider any factor(s) that may have contributed to the accident, including equipment, policies, procedures and/or personnel.)      |
| Recommendation(s)/Preventive Measure(s):      |
| Name and Title (please print):      | Signature: | Date:      |
| **V.P. of Administrative Services** | **Human Resources** |
| Signature: | Date:      | Number of Days Away From Work:      |