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 involved?_____

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