

**TOWN OF MOREHEAD CITY**  
**EMPLOYEE'S REPORT OF INJURY FORM**  
(Form must be forwarded to the Office of Human Resources immediately)

**EMPLOYEE'S ACCIDENT/INJURY SECTION**

Name:		Social Security No:	
Address:		Date of Birth:	Sex: M F
		Hire Date:	
Home Phone No: Cell Phone No:	Marital Status:	Dept/Job Title:	

**INJURY/ILLNESS/NEAR MISS**

I am reporting a work related (circle one): Injury      Illness      Near Miss

Date of injury/near miss: \_\_\_\_\_ Time of injury/near miss:      a.m.      p.m.

Time employee began work:      a.m.      p.m.      Date supervisor notified: \_\_\_\_\_

Person injury/near miss reported to: \_\_\_\_\_ Witness(es): \_\_\_\_\_

Type of injury/illness (fall, auto accident, etc): \_\_\_\_\_

Location or Department of injury/near miss (street address, building, etc): \_\_\_\_\_

Employer's premises?    Yes      No

Activity employee was performing just before injury/near miss occurred: \_\_\_\_\_

Describe step by step what led up to injury/near miss (continue on back if necessary): \_\_\_\_\_

Object or substance that directly harmed the employee: \_\_\_\_\_

What part(s) of your body were injured? (body part (left or right), type of pain, etc): \_\_\_\_\_

Has this body part been injured before?      If so, when?

What could have been done to prevent this injury/near miss? If a near miss, how could you have you been hurt?

Initial Treatment:    ___ No Medical Treatment ___ Minor-By Employer ___ Urgent Care Facility ___ Physician ___ Hospital Emergency Room ___ Hospitalized as In-Patient Overnite	Name of Treating Physician:
	Address of Treatment Facility:

Did you work entire day?    Yes    No      If no, what time did you leave work?

<b>EMPLOYEE SIGNATURE:</b>		<b>DATE:</b>	
For office use	Case #:	Prepared By:	Date:

**SUPERVISOR'S ACCIDENT INVESTIGATION SECTION**

Name of Injured Person \_\_\_\_\_

Date of Birth \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(Circle one) Male Female

What part of the body was injured? Describe in detail. \_\_\_\_\_

\_\_\_\_\_

What was the nature of the injury? Describe in detail. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Names of all witnesses:

\_\_\_\_\_

\_\_\_\_\_

Date of Event \_\_\_\_\_ Time of Event \_\_\_\_\_

Exact location of event: \_\_\_\_\_

What caused the event? \_\_\_\_\_

\_\_\_\_\_

Were safety regulations in place and used? If not, what was wrong? \_\_\_\_\_

\_\_\_\_\_

Did employee go doctor/hospital? Yes No

Doctor/Hospital Name \_\_\_\_\_

Recommended preventive action to take in the future to prevent reoccurrence.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

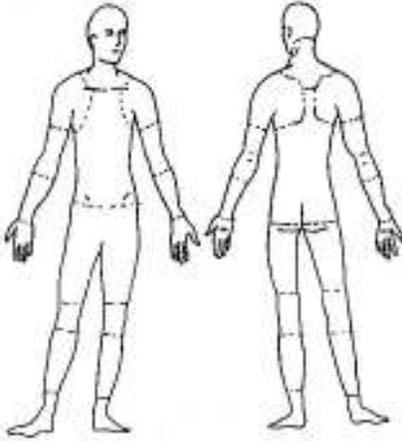
\_\_\_\_\_

## INCIDENT INVESTIGATION SECTION

**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="checkbox"/> Death <input type="checkbox"/> Injury <input type="checkbox"/> Lost Time <input type="checkbox"/> Dr. Visit Only <input type="checkbox"/> First Aid Only <input type="checkbox"/> Near Miss	
Date of incident:	This report is made by: <input type="checkbox"/> Employee <input type="checkbox"/> Supervisor <input type="checkbox"/> Team <input type="checkbox"/> Other _____

### Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	
Department:	Job title at time of incident:		
Part of body affected: (shade all that apply)  	Nature of injury: (most serious one) <input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system: <input type="checkbox"/> Other _____	This employee works: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary	
		Months with this employer	
		Months doing this job:	

### Step 2: Describe the incident

Exact location of the incident:	Exact time:
What part of employee's workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other _____	
Names of witnesses (if any):	

<b>Number of attachments:</b>	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="checkbox"/>
--

### Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)

- Inadequate guard
- Unguarded hazard
- Safety device is defective
- Tool or equipment defective
- Workstation layout is hazardous
- Unsafe lighting
- Unsafe ventilation
- Lack of needed personal protective equipment
- Lack of appropriate equipment / tools
- Unsafe clothing
- No training or insufficient training
- Other: \_\_\_\_\_

Unsafe acts by people: (Check all that apply)

- Operating without permission
- Operating at unsafe speed
- Servicing equipment that has power to it
- Making a safety device inoperative
- Using defective equipment
- Using equipment in an unapproved way
- Unsafe lifting
- Taking an unsafe position or posture
- Distraction, teasing, horseplay
- Failure to wear personal protective equipment
- Failure to use the available equipment / tools
- 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?  Yes  No

If yes, describe:

Were the unsafe acts or conditions reported prior to the incident?

Yes  No

Have there been similar incidents or near misses prior to this one?

Yes  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)

Completed by:

Title:

Department:

Date:

Names of investigation team members (if any):

Reviewed by:

Title:

Date:

