

## INCIDENT REPORT

### (INJURY/OCCUPATIONAL ILLNESS AND/OR ACCIDENT OR NEAR MISS)

#### Keene State College

**INSTRUCTIONS FOR PERSON COMPLETING THIS FORM:** Please complete Section 1 of this form for any type of incident. Section 2 must also be completed if there has been an injury. **Section 3 must be completed by a supervisor or appropriate campus official for any incident involving an employee;** and Section 4 must be completed by a supervisor or appropriate campus official for any employee who sought medical attention.

**This report must be filed with the KSC Human Resource Management Office within two (2) days of date of incident/injury/illness.**

<b>Section 1:</b> This Section must be completed for any type of incident listed below.			
Type of Incident:	Injury _____	Accident _____	Hazard _____
			Near Miss _____
Date of Incident:	_____	Time:	_____
			Day of Week: _____
Employee:	Faculty _____	Staff _____	Complementary _____
			Student Worker _____
Other:	Student _____	Visitor _____	Contract Employee: _____
Name:	_____	Date of Birth:	_____
			Male / Female _____
Home Address:	_____		Zip Code _____
Home Phone:	_____	Work Phone:	_____
Occupation:	_____	Department:	_____
Location where incident occurred: _____			
Describe the injury, accident, or incident. Include what was being done, how, with what tools and in what conditions. Use drawings or maps and additional sheets if necessary.			
<b>Cause of Incident (circle all that apply):</b>			
Animal	Electricity	Repetitious movement	Machinery
Insect	Hit by object	Slip or Fall	Tool
Plant	Hot liquid/object	Weather	Sharp object
Chemical	Lifting action	Quality of Air	Needle
Person	Twist	Airborne particle	Fire/Explosion
Criminal Act	Pinch/squeeze	Car accident	Other: _____
Witness(es) (list witness(es) names(s), address(es), phone numbers and attach statement(s)):			

<b>Section 2:</b> This Section must be completed if there has been an injury/illness.			
Injured body part (if applicable): _____			
<b>Injury type (circle all that apply)</b>			
Cut/puncture	Splinter	Body fluid exposure	Fumes/dust/smoke inhalation
Bruise	Heart attack	Electrical shock	Other respiratory
Muscle pull/strain/sprain	Stroke/seizure	Hernia	Vision loss
Bite/scratch	Repetitive stress	Rash/dermatitis	Hearing loss
Broken/fractured bone	Heat exhaustion	Allergic reaction	Death
Amputation	Concussion	Stress	Other: _____
Did you seek medical treatment?    yes / no            If yes, where? _____		Admitted to hospital overnight? yes / no	
<b>If yes, and victim is employee, Section 4 must be completed.</b>		If yes, how many days? _____	

Signature of person reporting injury/occupational illness: \_\_\_\_\_

Date: \_\_\_\_\_

**Section 3:** This Section must be completed by supervisor or appropriate campus official any time an incident has been reported.

Was the employee doing something other than his/her required duties at the time of the injury? \_\_\_\_\_

If yes, what, why, and directed by whom? \_\_\_\_\_

Describe in detail what the employee was doing, how it was being done and tools, people or machines involved. If possible give details such as weights, heights, temperatures, chemicals, etc.

What caused the incident/injury/illness to occur (please circle all that apply)?

**Environmental**

Improper or defective equipment  
 Location (poor layout, poor lighting)  
 Poor housekeeping (clutter, spillage, breakable objects)  
 Poor ergonomics (lifting, workstation design, inadequate tools)  
 Inadequate safeguards, unsafe job design  
 Other: \_\_\_\_\_

**Personal**

Lack of personal protective equipment  
 Lack of skill, training or experience  
 Improper apparel (loose clothing, jewelry, etc.)  
 Bodily conditions (fatigue, physical/mental impairment)  
 Adequate skill but failure to execute and follow direction  
 Other: \_\_\_\_\_

Describe results of accident investigation (Why did this incident occur and can something be done to avoid a recurrence? If reporting a hazard, suggestions for minimizing or eliminating the hazard):

**Section 4:** The following information must be completed by supervisor or appropriate campus official if there has been an injury/incident requiring medical attention.

Date of Hire: \_\_\_\_\_ Hours worked/Day: \_\_\_\_\_ Days worked/Week: \_\_\_\_\_

Hourly Rate: \$ \_\_\_\_\_ or Annual Rate: \$ \_\_\_\_\_ Occupation: \_\_\_\_\_

Was the employee given the WC information on approved providers? yes / no Soc. Sec. No.: \_\_\_\_\_

Lost time? yes / no If yes, beginning date: \_\_\_\_\_

Has injured returned to work? yes / no If yes, date returned: \_\_\_\_\_

**NOTE:** If no lost time as of the date of this report, please send written documentation of lost time when it occurs.

Date injury/illness reported to supervisor or campus official: \_\_\_\_\_

Name of supervisor or campus official (print): \_\_\_\_\_

Signature supervisor or campus official: \_\_\_\_\_

Date: \_\_\_\_\_