Facility Operations Accident, Incident and Near Miss Form

Employee Section:

Instructions: Employees shall use this form to report all work related injuries, illnesses, or "near miss" events (which could have caused an injury or illness) - no matter how minor. This helps us to identify and correct hazards before they cause serious injuries. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

Name of Injured Person: ____________________________________________
Date of Event: ____________________________________________________
Exact Location of Event: __________________________________________
Were you injured? ________ If Yes, was this reported to OEHS? ____________
What Part of the Body and what was the nature of the injury? * Describe in detail

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Describe fully how the accident happened, what was the employee doing prior to the event? What equipment or tools were being used? * Building, Floor, Room - be specific

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Name of all witnesses:
____________________________________________________________________
____________________________________________________________________

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

How can future accident, incident or near miss be prevented?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Recommended training to prevent reoccurrence?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Supervisor *please print: ____________________________
District: ____________________________ Core:

Supervisor section:

Supervisor signature: ____________________________
Phone Number: ____________________________ Date: ____________________________

*If injury occurred advise employee to complete the WCF E-1 form

Other details: ____________________________