Revised 02/08/2011

WESTERN KENTUCKY UNIVERSITY

EMPLOYEE ACCIDENT / NEAR-HIT
INVESTIGATION REPORT

FIRST TWO PAGES TO BE COMPLETED BY SUPERVISOR ONLY

Incident #:

Please follow these instructions for this form:

1.) Fill out entire form and check for errors

2.) Print and fax a SIGNED copy to Human Resources at 745-5037 and the designated department representative

3.) Fax report to Jennifer McLeod if you are with the Department of Facilities Management

IDENTIFYING INFORMATION

INJURY OR ILLNESS

1.) Location where accident occurred:	2.) Employer's Premises:	3.) Date of accident or illness:

4.) Injured Employee's Name:	5.) Employment Status of injured:	6.) Time of accident:	AM or PM?

7.) Occupation/ Job Title:	8.) Was the job task required?	9.) Home Department:

10.) Object / Equipment / Substance inflicting Harm:	11.) Part of body effected or injured:	12.) Location:

13.) Nature of Injury or illness:

RISK

20.) Estimate of Severity	21.) Loss Severity Potential	22.) Probability of Occurrence:
☐ Return to Normal Duties	☐ Minor	☐ Low
☐ Light Duty- Work Restriction	☐ Serious	☐ Moderate
☐ Lost Work Days	☐ Major	☐ High

DESCRIPTION

23.) Describe how the event occurred, include details about equipment or materials used, including the size and weight:

Report must be completed and submitted within 24 hours of the date of incident or as soon as practical.

CAUSE CHECK LIST

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS

	24.) Contributing Actions (Check all that apply)		25.) Contributing Conditions
☐	Operating Equipment Without Authority	☐	Fire and Explosion Hazards
☐	Failure to Warn	☐	Poor Housekeeping or Disorder
☐	Failure to Secure	☐	Hazardous Environment: gas; dust; smoke; or vapor
☐	Operating at Improper Speed	☐	Noise Exposure
☐	Removing Safety Devices	☐	Asbestos or Radiation Exposure
☐	Using Defective Equipment	☐	High or Low Temperature Exposure
☐	Using Equipment Improperly	☐	Inadequate or Excess Illumination
☐	Failing to use Personal Protective Equipment	☐	Inadequate Ventilation
☐	Improper Loading	☐	Repetitive Motion
☐	Improper Placement	☐	Inadequate Guards or Barriers
☐	Improper Lifting	☐	Inadequate or improper protective equipment
☐	Improper Position for Task	☐	Defective Tools, Equipment or Materials
☐	Servicing Equipment in Operation	☐	Congestion or Restricted Action
☐	Horseplay	☐	Inadequate Warning System

Explain any other Contributing Actions:

Explain any other Contributing Conditions:

	26.) Personal Factors		27.) Job Factors		28.) Type of Contact:
☐	Inadequate Capability	☐	Inadequate Supervision	☐	Struck By/ Against
☐	Inadequate Training/Knowledge	☐	Inadequate Engineering	☐	Trip
☐	Lack of Skill / Experience	☐	Inadequate Purchasing	☐	Caught In
☐	Stress	☐	Inadequate Maintenance	☐	Caught On
☐	Improper Motivation	☐	Inadequate Tools / Equipment	☐	Caught Between
☐	Other	☐	Inadequate Work Standards	☐	Slip
		☐	Wear & Tear	☐	Fall on Same Level
		☐	Abuse or Misuse	☐	Fall Below
		☐	Other	☐	Other

ACTION

29.) **Remedial Action**: Supervisor's corrective action to ensure this type of accident does not recur.

Action Items: (What's to be done)		By Whom?	Time Frame:	Completion Date:
a)				
b)				
c)				

	Yes or No
Do safety rules and procedures exist for the job task being performed by the employee?	
Was employee trained in the appropriate use of Personal Protective Equipment / Proper safety procedures?	
Was employee cautioned for failure to use Personal Protective Equipment / Proper safety procedures?	
Did employee promptly report the injury / illness?	
Is there modified duty available?	

30.) Supervisor/ Investigator's Name:	31.) Phone Number:		32.) Date:
33.) Manager/Director Name	34.) Investigation is complete and accurate		35.) Date:

Is Picture of Accident Site attached?	

EMPLOYEE - STATEMENT

To be completed by Employee ONLY

EMPLOYEE STATEMENT

Was this an Incident Accident or a Near Hit?	

(Please Print) To be completed by Employee

Date of Injury:	Shift:	Time:	AM or PM:

Employee Name:	WKU ID:

Job Title:	Was this incident a New Injury or a Recurrence?

Location of Incident:	First reported to:

List any witnesses to this occurrence:

a)		**b)**	
c)		**d)**	
e)		**f)**	

Describe what you were doing with the incident occurred:

Describe the location of the injury (right/ left) on your body:

Following the incident, which of the following actions took place?

☐	Report Only	☐	Medical Treatment
☐	Emergency Room Treatment	☐	First Aid

Doctor's Name:	Hospital Name:

List safety equipment in use at time of incident:

a)		**b)**	
c)		**d)**	
e)		**f)**	

In your opinion, what was the cause of this accident? (I.E.: lack of training, carelessness, improper lifting, etc.)

What measures do you suggest to prevent future accidents/ near misses of this type? (I.E.: cite unsafe conditions and corrective measures suggested)

Other comments:

Employee Signature:	Date:

To be completed and returned by end of scheduled shift

WITNESS -STATEMENT

To be completed by Witness ONLY

WITNESS STATEMENT

Was this an Incident an Accident or a Near Hit?	

(Please Print) To be completed by any Witnesses

Date of Witnessed Incident:	Shift:	Time:	AM or PM:

Name of Witness:	Job Title of Witness:

Name of Injured Employee (if applicable):	Location of Incident:
Bodily Location of Injury:	Did you actually witness the incident?

Describe the incident in detail:

Describe what you were doing at time of the incident:

Did you hear or see anything prior to the incident? If so, what?

Where was your location to the occurrence? (Ex. 5-6 feet away, within 2 feet), right or left etc.)

What was the apparent cause of the incident?

Please list suggestions to help prevent future occurrences of this type:

Other Comments:

Witness Signature:	Date:

To be completed and returned by end of scheduled shift