



# Occupational / Non-Occupational Injury/Illness & Incident Report

RETURN TO: Dept. of Environmental Health & Safety  
047 Biological Sciences II

Phone: (937) 775-2215 // Fax: (937) 775-3761

NOTE FOR EMPLOYEES: Complete this form, SUPERVISOR, CHAIR or DIRECTOR signature is required

## Completed form to be forwarded to EHS on day of injury, illness or incident

Name: \_\_\_\_\_

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Campus Address (Room/Bldg): \_\_\_\_\_ Work Phone No.: \_\_\_\_\_

Work Location: \_\_\_\_\_

Home Address (contrators/visitors): \_\_\_\_\_ Phone No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Date Hired: \_\_\_\_\_  N/A

Status:  Employee  Student Employee  Contractor  Student  Visitor  Volunteer

## The Accident / Injury / Exposure or Near Miss Incident:

Incident Date: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM  Time cannot be determined

Time began work: \_\_\_\_\_  AM  PM Injury event occurred at a university sponsored event?  Yes  No

Where did the incident occur? \_\_\_\_\_ Did the incident occur on university property?  Yes  No

Type of incident:  Break  Bruise  Burn  Cut/laceration  Exposure  Fall  Slip/trip  Near miss

Areas of body injured or exposed: \_\_\_\_\_

What was the individual doing before the incident occurred? \_\_\_\_\_

What happened? \_\_\_\_\_

What was the exposure, injury or illness? \_\_\_\_\_

The object/substance directly causing harm: (If this question does not apply to the incident, leave it blank):  
\_\_\_\_\_

If the individual died, when did the death occur? Date of death: \_\_\_\_\_  Not applicable

Lost work time? (excludes date of incident):  Yes  No

Restricted work time? (excludes date of incident):  Yes  No

## Responsible Supervisory Person

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

Printed Name: \_\_\_\_\_ Work No.: \_\_\_\_\_

Official Title: \_\_\_\_\_ Address (Room/Bldg): \_\_\_\_\_

## Medical Treatment Received/Required

Declined Treatment  No Treatment Required  First Aid Only  ER/Urgent Care  In-Patient Hospitalization

Name of Physician or health care professional: \_\_\_\_\_

Street: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Follow-up investigation: corrective action needed?  Yes  No

Contributing Items/Issues: \_\_\_\_\_

Corrective action:  Elimination/Substitution  Engineering Controls  Warnings  Training  PPE Assessment

Contacts & Date: \_\_\_\_\_

Preventive Measures: \_\_\_\_\_

**EHS USE:**  Occupational  Non-Occupational  Incident Report Case File#: \_\_\_\_\_

Recordable  Non-Recordable No. of Lost Work Days \_\_\_\_\_ No. of Restricted Work Days \_\_\_\_\_

Copy of form forwarded to:  Office of General Counsel  Office V. Pres. of Student Affairs  Contact Management

# The Occupational & Non-Occupational Injury/Illness & Incident Report Form:

Complete this Form and return it to the Department by the end of the work day. If there are questions about completing the Form contact the Department at (937) 775-2215 during regular business hours.

## For Employee, Student Employee and Student

All accidents, exposures, injuries and near miss accidents are to be recorded on this Form. Return this Form to the Department of Environmental Health and Safety by the end of the work day to allow for follow up documentation or investigation.

## For Visitors or Contractors:

Complete this Form to report accidents, injuries or exposure incidents or a near miss incident. Return this Form to the Department of Environmental Health and Safety by the work day to allow for follow up documentation or investigation. Contractors working on Wright State property under direct contractor direction must report their injury accidents to their employer using the appropriate OSHA form.

## What is a Near Miss Incident?

A near miss is a situation where an injury did not occur but could have. Examples of a near miss would include non-injury or exposure situations such as falling on steps, slipping or falling on ice, falling off ladder, or dropping and breaking a chemical bottle in a lab.

## What is Lost or Restricted work time?

Under orders from prescribing doctor or health care professional this is the number of days you are not able to perform your normal work activities, excluding the day of the injury. If you were able to return to work the day following the accident/injury incident there is no lost or restricted work time.

## Responsible Supervisory Person:

(i.e.; Supervisor, Department Chair, Dean, Director, V. President, or President) The person responsible for supervising the work or activity of the injured person is the person responsible for completing the Form.

## Medical Treatment:

Mark the highest level of treatment given in response to the injury/illness incident. What medical treatment was given?

Did the injured person refuse treatment?

First Aid treatment is defined by OSHA as being: Using non-prescription drugs at non-prescription strength; receiving tetanus shot; flushing/soaking skin wounds; using band-aid type covering to cover wounds; using hot/cold therapy; using non-rigid supports; using temporary immobilization devices for transport; drilling of nail to relieve pressure or drain fluid from a blister; use of an eye patch; use tweezers, swabs or simple means to remove splinter or other foreign material from body other than eye; irrigation or swab used to remove material from eye; use of finger guard; massages and drinking fluids for heat stress relief.

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## Follow up Investigation by the Department of Environmental Health and Safety

Cause of accident, exposure and other contributing factors:

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Corrective Actions (Engineering Controls, Repairs or Replacement of Tools/Equipment, Personnel Training):

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Preventive Measures (General Awareness Notifications, Posting, PPE, Training):

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