Town of Harrisburg
Accident / Injury / Illness / Exposure
Report and Investigation

Instructions: This form is to be completed on all accidents that involve personal injury, infectious exposure, or property damage. Please print or type. Fill in all blanks. Write N/A if a blank does not apply to this accident/injury/illness/exposure. When completed, return this form to the Safety & Health Officer within two (2) working days from date of incident.

To be completed by Employee immediately following the incident:

Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM

Date Reported to Supervisor: _____ Name of Supervisor: _____

Location of Incident:

Employee Name: _____ Employee Number: _____ Sex: _____

Department: _____ Birth date: _____ Home Phone: _____

Employee's brief description of Incident:

Exposure to Infectious Disease

Name of person to whom exposed: _____

Age of person to whom exposed: _____ Sex of person to whom exposed: ☐ Male / ☐ Female

Home address of person to whom exposed: _____

Suspected or Confirmed Disease: _____

Type of incident (auto accident, trauma, arrest, etc.): _____

Person transported to: _____ Transported by: _____

What was Employee exposed to: ☐ Blood / ☐ Tears / ☐ Feces / ☐ Urine / ☐ Saliva / ☐ Vomit / ☐ Sputum / ☐ Sweat / ☐ Other

What part of body was exposed: ☐ Right / ☐ Left _____

Describe any open cuts, sores, rashes, etc. that became exposed:

Did employee receive medical attention?

☐ No medical attention necessary ☐ Employee declined medical attention

☐ Medical attention received:

Employee Signature: _____

Amended 9/2017

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To be completed by Supervisor within 48 hours following incident:

Name(s) employee(s) involved in incident: _____

List equipment involved in incident: _____

Name(s) and contact information of witnesses:

Name: _____ Phone # _____

Name: Phone #

☐ **Personal Injury**	☐ **Property Damage**
Type of Injury (cut, bruise, fracture, sprain, strain, etc.):	Property damaged: _____
	Type of damage: _____
Injured body part (arm, leg, back, etc.): ☐ Right / ☐ Left	Vehicle #: _____
	VIN #:

Basic Cause of Accident / Injury: (check all that apply)

Unsafe Actions:	**Unsafe Conditions**	
☐ Improper work technique	☐ Unsafe operating method	Was safety regulation provided?
☐ Safety rule violation	☐ Improper maintenance	☐ Yes ☐ No
☐ Operating without authority	☐ Poor workstation design	Was safety equipment provided?
☐ Failure to warn or secure	☐ Lack of direct supervision	☐ Yes ☐ No
☐ Operating at improper speeds	☐ Insufficient training	Was safety equipment in use at the time of the incident?
☐ Bypassing safety devices	☐ Lack of experience	☐ Yes ☐ No
☐ Protective equipment not in use	☐ Slippery conditions	Was accident caused by failure to use safety equipment or follow safety regulation?
☐ Improper loading or placement	☐ Excessive noise	☐ Yes ☐ No
☐ Unsafe position or posture	☐ Inadequate guarding of hazards	
☐ Use of defective equipment	☐ Defective tools/equipment	If yes, explain:
☐ Use of improper equipment	☐ Poor housekeeping	
☐ Did not follow standard procedure	☐ Insufficient lighting	
☐ Horseplay	☐ Close clearance	
☐ No Unsafe action	☐ No unsafe condition	
☐ Other	☐ Other	

Prevention: (check all that apply)

What action(s) are needed to prevent this type of incident from happening again?

☐ Retraining of employee — Date retraining completed: _____

☐ Unsafe condition guarded — Date unsafe condition guarded: _____

☐ Unsafe condition corrected — Date unsafe condition corrected: _____

☐ Other preventative action:

Investigated by:

Supervisor signature: Date:

Reviewed by:

Department Head signature: Date:

Safety Officer signature: Date:

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MEDICAL TREATMENT/FOLLOW UP REPORT

Name of Employee: _____ Date: _____

Did you seek medical treatment? Yes _____ No _____ (***If No, explain why?)***

_____

_____

Where did you get medical treatment? _____

Who provided medical treatment? (Doctor's name) _____

What were you treated for? _____

What medical procedures were done? _____

Any type follow-up required? Yes _____ No _____ ***(If yes, please list dates below***)

_____ (Date) Were you released for duty? Yes _____ No _____
_____ (Date) Were you released for duty? Yes _____ No _____
_____ (Date) Were you released for duty? Yes _____ No _____
_____ (Date) Were you released for duty? Yes _____ No _____

Any restricted duties? Yes _____ No _____ ***If yes, How Long?*** _____

Did you receive a prescription? Yes _____ No _____

Did you receive a note from the doctor for light duty or released for work? _____

On what day were you released from light or restricted duty? _____

Employee's Signature: *(required)* _____ Date: _____

Note: This form must be completed before employee returns to work. All paperwork received from the doctor should be attached to this form.

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Safety Committee comments: **Date Reviewed:**

Safety Committee Chairman Signature:_____