

Please use the following information to correctly identify injuries.

### **How does OSHA define a recordable injury or illness?**

- \* Any work-related fatality
- \* Any work-related injury or illness that results in loss of consciousness, days away from work, restricted work, or transfer to another job
- \* Any work-related diagnosed case of cancer, chronic irreversible diseases, fractured or cracked bones or teeth, and punctured eardrums
- \* There are also special recording criteria for work-related cases involving: needle-sticks and sharps injuries; medical removal; hearing loss; and tuberculosis
- \* Wound closing devices such as sutures, staples, etc.
- \* Using devices with rigid stays or other systems designed to immobilize parts of the body
- \* Removing foreign bodies from the eye using magnets or eye loops
- \* Physical therapy or chiropractic treatment for a documented incident
- \* Prescriptions or documenting use of non-prescription strength medication above normal dosage

### **How does OSHA define FIRST AID?**

- \* Using a non-prescription medication at nonprescription strength. OSHA has yet to define what medications constitute non-prescription medication at prescription strength.
- \* Administering tetanus immunizations
- \* Cleaning, flushing or soaking wounds on the surface of the skin
- \* Using wound coverings such as bandages, Band-Aids™, gauze pads, etc.; or using butterfly bandages or Steri-Strips
- \* Using hot or cold therapy
- \* Using any **non**-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.
- \* Using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, back boards, etc.)
- \* Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister
- \* Using eye patches
- \* Removing foreign bodies from the eye using only irrigation or a cotton swab
- \* Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means
- \* Using finger guards
- \* Using massages
- \* Drinking fluids for relief of heat stress
- \* X-Rays to determine extent of injury

Let me give an example. When an employee seeks medical care for a non-serious injury and x-rays are ordered and a tetanus shot is given because they fell and scraped their arm on something metal it is considered FIRST AID. Now if the treating physician recommends (on paper) that the employee take more than the recommended dosage of over the counter Ibuprofen or Tylenol for pain it “could” be considered a recordable. If they prescribe **ANY** medication it immediately becomes a recordable even if it is Ibuprofen 800.

For further information, please visit <https://www.osha.gov/recordkeeping/index.html>



# Method of Procedure

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## Incident and Safety Management

Date \_\_\_\_\_ Name of Employee \_\_\_\_\_

Time of Incident \_\_\_\_\_ Location \_\_\_\_\_

Incident \_\_\_\_\_ First Aid \_\_\_\_\_ Near Miss \_\_\_\_\_

- Immediate care for the injured
- Area secured to prevent additional injuries
- Witness information

\_\_\_\_\_  
\_\_\_\_\_

- Determination of Injury

\_\_\_\_\_  
\_\_\_\_\_

- Who escorted Injured to Clinic/Hospital \_\_\_\_\_

- Reports taken

Injured \_\_\_\_\_

Witness \_\_\_\_\_ (2) Witness \_\_\_\_\_

Supervisor \_\_\_\_\_

- Drug test Y\_\_\_\_ N\_\_\_\_

- Clinic or Hospital Contact \_\_\_\_\_

\_\_\_\_\_

- Follow-up Report Completed Y \_\_\_\_\_ N\_\_\_\_\_

a. Completed by \_\_\_\_\_

b. Date(s) \_\_\_\_\_



## Employee's Report of Injury Form

**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.

I am reporting a work related: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of injury/near miss:	Time of injury/near miss:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when?	Supervisor:
Your signature:	Date:



### Supervisor's Accident Investigation Form

Name of Injured Person \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(Circle one) Male Female

What part of the body was injured? Describe in detail. \_\_\_\_\_

What was the nature of the injury? Describe in detail. \_\_\_\_\_

Describe fully how the accident happened? What was employee doing prior to the event? What equipment, tools being using? \_\_\_\_\_

Names of all witnesses:

\_\_\_\_\_  
\_\_\_\_\_

Date of Event \_\_\_\_\_ Time of Event \_\_\_\_\_

Exact location of event: \_\_\_\_\_

What caused the event? \_\_\_\_\_

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

Employee went to doctor/hospital? Doctor's Name \_\_\_\_\_

Hospital Name \_\_\_\_\_

Recommended preventive action to take in the future to prevent reoccurrence.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date



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## Incident Investigation Report

**Instructions:** Complete this form as soon as possible after an incident that results in serious injury or illness.  
 (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness.*)

This is a report of a: <input type="checkbox"/> Death <input type="checkbox"/> Lost Time <input type="checkbox"/> Dr. Visit Only <input type="checkbox"/> First Aid Only <input type="checkbox"/> Near Miss	
Date of incident:	This report is made by: <input type="checkbox"/> Employee <input type="checkbox"/> Supervisor <input type="checkbox"/> Team <input type="checkbox"/> Other _____

### Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:
Department:	Job title at time of incident:	
Part of body affected: (shade all that apply)	Nature of injury: (most serious one)	This employee works:
	<input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system: <input type="checkbox"/> Other _____	<input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
		Months with this employer
		Months doing this job:

### Step 2: Describe the incident

Exact location of the incident:	Exact time:
What part of employee's workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other _____	
Names of witnesses (if any):	



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<b>Number of attachments:</b>	Written witness statements:	Photographs:	Maps / drawings:
What personal protective equipment was being used (if any)?			
Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.			
Description continued on attached sheets: <input type="checkbox"/>			

<b>Step 3: Why did the incident happen?</b>	
Unsafe workplace conditions: (Check all that apply) <input type="checkbox"/> Inadequate guard <input type="checkbox"/> Unguarded hazard <input type="checkbox"/> Safety device is defective <input type="checkbox"/> Tool or equipment defective <input type="checkbox"/> Workstation layout is hazardous <input type="checkbox"/> Unsafe lighting <input type="checkbox"/> Unsafe ventilation <input type="checkbox"/> Lack of needed personal protective equipment <input type="checkbox"/> Lack of appropriate equipment / tools <input type="checkbox"/> Unsafe clothing <input type="checkbox"/> No training or insufficient training <input type="checkbox"/> Other: _____	Unsafe acts by people: (Check all that apply) <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Servicing equipment that has power to it <input type="checkbox"/> Making a safety device inoperative <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting <input type="checkbox"/> Taking an unsafe position or posture <input type="checkbox"/> Distraction, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment / tools <input type="checkbox"/> Other: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Is there a reward (such as “the job can be done more quickly”, or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If yes, describe:	
Were the unsafe acts or conditions reported prior to the incident? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
Have there been similar incidents or near misses prior to this one? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	



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**Step 4: How can future incidents be prevented?**

**What changes do you suggest to prevent this incident/near miss from happening again?**

- Stop this activity     Guard the hazard     Train the employee(s)     Train the supervisor(s)
- Redesign task steps     Redesign work station     Write a new policy/rule     Enforce existing policy
- Routinely inspect for the hazard     Personal Protective Equipment     Other: \_\_\_\_\_

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets:

**Step 5: Who completed and reviewed this form? (Please Print)**

Written by:	Title:
Department:	Date:

Names of investigation team members:

Reviewed by:	Title:
	Date:



## Incident Investigation - Witness Statement

Name \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_

Worksite \_\_\_\_\_ Accident Date \_\_\_\_\_ Time \_\_\_\_\_

Supervisor Name \_\_\_\_\_

Contact Number \_\_\_\_\_

Thank you for helping us analyze this incident so that we can help prevent someone from getting hurt or sick in the future. Accuracy is very important in helping us get to the root cause of this incident.

Please describe what you saw and heard in chronological order.

**What was the injured doing at the time of the incident?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What were you doing when the incident occurred?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What did you do after the incident occurred and who was the incident reported to?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please answer the following questions:  
What was the condition of the tools, equipment, machinery and materials involved in the incident?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**What was the work environment like? Was it very hot or cold, wet, slippery, windy, etc.?**

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**What was the type and condition of the Personal Protective Equipment (PPE) being used by the injured person when the incident occurred?**

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**What were the instruction or training you and others received for the task being performed when the incident occurred? Please describe the training you received. Use other side of paper if needed.**

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**What was the direction of travel, fall, or final resting place of the vehicle or equipment and individual involved in the accident (draw a diagram, if appropriate.)**

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**Who else witnessed or heard the incident?**

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**How do you think we can prevent this incident in the future?**

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**I certify that statement is true and accurate to the best of my recollection.**

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