**ST. JOHN FISHER ACCIDENT REPORT FORM**

**<u>SECTION 1:  INJURED PERSON'S REPORT</u> (Please use the back of the report for more room.)**

Full Name of injured person:  _____  Department: _____  Title: _____

Address City/State/Zip: _____  Phone #_____

Date of Birth:_____  Date hired:_____  (Please check) Male__  Female__

Days normally worked_____  Hours worked: _____  Shift _____

Injury Date: _____  Day of Week:_____  Occurrence time: _____a.m. _____p.m.

Date employer notified: _____  Person who received the first notice? _____

Accident Description –describe how the incident had occurred_____
_____

Nature of injury - state the nature of injury and part(s) of body affected (ex. right knee, lower back, etc.)
_____

What were you doing just before the accident occurred? _____

Where did the accident occur (exact location) and facility? _____

How did the accident occur?  _____

What factors led up to or contributed to the accident? _____

What were the weather conditions on the date of your accident? _____

What tools, equipment or substance was being used? _____

Was time away from work necessary? ____Y  ____N  Last Day worked: _____ Disability begin date: _____

Name and address of any witnesses: _____

Have you been provided medical treatment? ___Y ___N    Will you need medical treatment? ___Y ___N
Did you receive care on campus? ___Y ___N

If treatment was given away from the worksite, where was it given?  **Please provide the Name/Address of provider**:
_____

Were you treated in the emergency room?  ___Y ___N  Were you hospitalized overnight as an in-patient? ___Y ___N

EMPLOYEE SIGNATURE: _____  DATE: _____

**<u>SECTION II SUPERVISOR'S REPORT:</u>  PLEASE VERIFY THE INFORMATION IN SECTION 1**

When did you first know of the injury? _____

List the direct cause(s).  List both unsafe actions and unsafe conditions. _____
_____

List the root cause(s). _____
_____

List the actions that have been or will be taken to remove direct causes listed above by whom and when they are or will be done._____
_____

What additional actions need to be taken in the future? _____
_____

Has the employee returned to work? _____

If yes, what date? _____        Regular Duty___ Light Duty___


IMMEDIATE SUPERVISOR'S SIGNATURE: _____        DATE: _____

Revised May 2011