IMMEDIATELY SUBMIT COPY TO: TERESA CIOLKOSZ TCIOLKOSZ@BATES.CTC.EDU AND EMAIL COPY TO ARAMACHER@ERNWEST.COM

INCIDENT REPORT 07/11

COMPANY LOCATION: BATES TECHNICAL COLLEGE, 1101 SOUTH YAKIMA AVENUE, TACOMA, WA 98405

PART I TO BE COMPLETED BY EMPLOYEE

Employee:	Job Title:	Time Shift Began: _____ AM / PM (circle)
Date of Incident:	Time of Incident: ____AM / PM (circle)	Reported to Employer: _____/_____/_____
Employee's Home or Mailing Address:	Home Phone: ( )	Gender: [ ] Male [ ] Female
	Date of Hire: _____/_____/_____	
	Date of Birth: _____/_____/_____	Last Full Day Worked: _____/_____/_____

Seen by:

[ ] Emergency Room [ ] Urgent Care [ ] Other

Treating Caregiver's Name, Address & Phone:

_____

_____

_____

1) Were prescription drugs prescribed? [ ] Yes [ ] No
2) Will employee lose time from work? [ ] Yes [ ] No
3) Was employee placed on modified duty? [ ] Yes [ ] No
4) Was worker hospitalized overnight? [ ] Yes [ ] No
5) Was the incident fatal? [ ] Yes [ ] No
6) If fatal, date of death ___/____/___

Describe in detail what employee was doing <u>just before</u> the incident occurred including the activity, tools, equipment, and/or material being used

_____

_____

Describe how the incident occurred, including the activity being performed and objects, people associated with the injury

_____

_____

If applicable what object or substance directly harmed the employee (e.g. needle, exposure to pathogen): _____

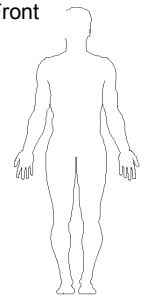
_____

Part of Body (Circle side if applicable)

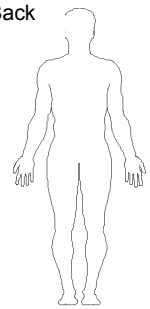
[ ] Head	[ ] Hand (L or R)	[ ] Knee (L or R)
[ ] Eyes (L or R)	[ ] Finger	[ ] Abdomen
[ ] Nose	[ ] Leg (L or R)	[ ] Entire
[ ] Mouth	[ ] Foot (L or R)	[ ] Glasses
[ ] Ear	[ ] Toes	[ ] Teeth
[ ] Shoulder (L or R)	[ ] Internal	[ ] Groin
[ ] Back	[ ] Multiple	[ ] Neck
[ ] Chest	[ ] Ankle (L or R)	[ ] Elbow (L or R)
[ ] Arm (L or R)	[ ] Wrist (L or R)	[ ] Rib
[ ] Hip	[ ] Face	

MARK INJURED AREA(s) BELOW

Front



Back



1) Rate of Pay _____ per mo/wk/hr 2) Days Worked per Week _____ 3) Hours per Week _____

4) Health Benefits **(circle)** Y or N 5) Monthly benefits (med/vision) paid $_____ per mo/wk/hr

HR Fill out this section if employee misses more than one day of work.

PART II TO BE COMPLETED BY EMPLOYEE

Was injury work related? [ ] Yes [ ] No

I understand light work is available to me. [ ] Yes [ ] No

Employee statement of how incident occurred: _____

_____

_____

<u>MEDICAL RELEASE AUTHORIZATION:</u> I hereby authorize my physician, clinic, hospital, agency, HMO network or therapy provider to release to my employer's representative any medical records regarding current or previous treatment(s) that has been furnished to me.

Employee's Signature_____ Date _____

Form Completed By: _____ Phone: _____ Date: _____ Title: _____

OSHA Log case number _____ (transfer the case number from the OSHA 300 log after recording the case)

FOR COLLEGE OPERATIONS OFFICE USE ONLY: ☐Human Resources ☐Safety Officer ☐Risk Manager ☐Supervisor ☐Employee