Employee Incident Report

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This form must be completed and submitted to your Supervisor or Department Head within 24 hours or as soon as possible following an injury or incident. The Supervisor or Department Head must complete the form and file it with the Insurance Liaison within 48 hours or as soon as possible following the incident.

EMPLOYEE TO COMPLETE

PART 1: EMPLOYEE INFORMATION

Last Name	*First Name*			
Job Title	*Work Phone*	*Home Phone*		
Supervisor Name (Last, First)	*Title*	*Work Phone*	Work Schedule: ☐ Full-time ☐ Part-time	*Bargaining Unit:* ☐ Yes ☐ No

PART 2: INCIDENT DESCRIPTION

Date of Incident	*Time of Incident*	*Location of Incident*
Resulted in employee injury/ illness? ☐ Yes → ☐ No	*Description of Injury/ Illness (type of injury/ illness & body part, e.g. sprained rt. ankle, severe cut on left thumb):*	

Incident details--

Specific task being performed at time of incident:	
Step-by-step events leading up to the incident:	
Equipment/ tools involved:	
Materials being handled:	
Other relevant details:	Continued on attached sheet: ☐

Witness Name(s)/Phone Number(s):

*Employee Signature*** ____ *Date* ______________________________

------------- Supervisor to complete next page ----------------

Lee County Illinois

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Employee Last Name:

SUPERVISOR TO COMPLETE

PART 3: ADDITIONAL INCIDENT INFORMATION

Supervisor Comments (additional information on nature of incident details, etc.) Note: If claim as submitted appears to be suspicious please notify your senior manager. Examples include: reported at start of shift; strain or sprain to back with no physical evidence of injury; employee vague about circumstances; supplemental information gathered indicates injury possibly not work-related.

Guidance: If treatment beyond first aid required then employee is to be transported by a supervisor or an ambulance to the clinic for evaluation and treatment. Once treatment and evaluation is completed then the employee will be transported back to their work.

If the employee is cleared to operate their personal vehicle then he/she will be allowed to leave the worksite. If the employee is impaired to the point that it is unsafe to operate their personal vehicle then the employee will have to obtain an alternative means to return home.

PART 4: POSSIBLE CAUSAL FACTORS

Process/ environment-related: (Check all that possibly apply)

- ☐ Housekeeping
- ☐ Work procedure, or lack of
- ☐ Repetitive motion
- ☐ Tool/ equipment condition
- ☐ Tool/ equipment availability
- ☐ Personal protective equipment availability
- ☐ Workstation/ area setup
- ☐ Flooring/ ground
- ☐ Lighting
- ☐ Ventilation
- ☐ Other:

Personnel-related: (Check all that possibly apply)

- ☐ Tool/ equipment use or selection
- ☐ Level of support/ assistance
- ☐ Awkward posture(s)
- ☐ Personal protective equipment use
- ☐ Following of procedure/ instruction
- ☐ Level of attention to task
- ☐ Work pacing
- ☐ Other:

POSSIBLE ROOT CAUSE(S): Factors contributing to the workplace condition(s)/ act(s) identified above

(Check all that possibly apply)

- ☐ Awareness of job hazards
- ☐ Level of training
- ☐ Level of inspection/ maintenance
- ☐ Level of communication
- ☐ Level of resources available
- ☐ Other:

Additional details on possible cause(s):

Treatment details: Where was employee treated?

What is the initial status: Return to full duty with no restrictions; return to duty with restrictions; lost time injury. List restrictions if applicable:

PART 5: PLANNED FOLLOW-UP EFFORTS

Check all that possibly apply:

- ☐ Conduct ergonomic evaluation (01)
- ☐ Evaluate equipment/ facility condition (02)*
- ☐ Provide appropriate tool/ equipment (03)
- ☐ Provide personal protective equipment (04)
- ☐ Provide initial/ refresher training (05)
- ☐ Post safety signage in area (06)
- ☐ Review inspection and/or maintenance program (07)
- ☐ Review formal work procedure (08)
- ☐ Assess newly identified hazard(s) (09)
- ☐ Review as job performance issue (10)
- ☐ Other (11):

FOLLOW-UP ACTION:

For each follow-up effort checked above, indicate its action code (# in parentheses) and describe the planned action. As actions are completed, record completion date, and initial the original copy for local recordkeeping purposes.

Action Code	*Description of Planned Action*	*Date Completed*	*Supervisor Initial*

*Supervisor Signature*** *Date*

*** Signing of this form does not constitute acceptance or assignment of individual fault*