

## Viterbo University Employee Accident Reporting Procedures

**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.

1. Report all accidents immediately to responsible party – Job supervisor
2. If clinic or emergency visit is required, the responsible party referred to above should accompany, or designate another individual to accompany, the injured person, and any witnesses.
3. This form must be completed within 24 hours of accident.
4. Employee is to complete pages 1-3 with detail, sign and submit to their direct supervisor
5. Supervisor is to complete pages 4 & 5 with detail, sign and notify Human Resources immediately of the accident and complete the accident report. Please connect with Alicia Wolfert in Human Resources at 608.796.3932 or [akwolfert@viterbo.edu](mailto:akwolfert@viterbo.edu). Human Resources will file appropriate insurance forms as required.

### EMPLOYEE SECTION

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? (location, building, office, street)	
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? What location on the body is the injury? (be as descriptive as possible - ex: My right hand on the left side of the middle finger near the second knuckle in which was burned by steam in a 1x .5 in circumference)

Did you see a doctor about this injury/illness?  Yes  No

If yes, whom did you see?	Doctor's phone number:
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Date:	Time:
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Has this part of your body been injured before?  Yes  No

If yes, when?	Supervisor:
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Your signature:	Date:
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Department:	Job title at time of incident:
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Part of body affected:	Nature of injury: (most serious one) <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	This employee works: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary
		Months/years with Viterbo
		Months/years doing this job:

<p>Unsafe workplace conditions: (Check all that apply)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Inadequate guard</li> <li><input type="checkbox"/> Unguarded hazard</li> <li><input type="checkbox"/> Safety device is defective</li> <li><input type="checkbox"/> Tool or equipment defective</li> <li><input type="checkbox"/> Workstation layout is hazardous</li> <li><input type="checkbox"/> Unsafe lighting</li> <li><input type="checkbox"/> Unsafe ventilation</li> <li><input type="checkbox"/> Lack of needed personal protective equipment</li> <li><input type="checkbox"/> Lack of appropriate equipment / tools</li> <li><input type="checkbox"/> Unsafe clothing</li> <li><input type="checkbox"/> No training or insufficient training</li> <li><input type="checkbox"/> Other:</li> </ul>	<p>Unsafe acts by people: (Check all that apply)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Operating without permission</li> <li><input type="checkbox"/> Operating at unsafe speed</li> <li><input type="checkbox"/> Servicing equipment that has power to it</li> <li><input type="checkbox"/> Making a safety device inoperative</li> <li><input type="checkbox"/> Using defective equipment</li> <li><input type="checkbox"/> Using equipment in an unapproved way</li> <li><input type="checkbox"/> Unsafe lifting</li> <li><input type="checkbox"/> Taking an unsafe position or posture</li> <li><input type="checkbox"/> Distraction, teasing, horseplay</li> <li><input type="checkbox"/> Failure to wear personal protective equipment</li> <li><input type="checkbox"/> Failure to use the available equipment / tools</li> <li><input type="checkbox"/> Other:</li> </ul>
<p>Why did the unsafe conditions exist?</p> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/>	
<p>Why did the unsafe acts occur?</p> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/>	
<p>Were the unsafe acts or conditions reported prior to the incident? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p>	
<p>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></p>	

\_\_\_\_\_  
 Employees Signature

\_\_\_\_\_  
 Date

### Supervisor's Accident Investigation Form

Name of Injured Employee \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

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

(Circle one) Male Female

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

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

Describe fully how the accident happened? What was the employee doing prior to the event? What equipment, tools were used?

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

Name of all Witnesses:

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

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

When you were notified \_\_\_\_\_

Exact location of Event \_\_\_\_\_

What caused the Event?

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

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

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

Did the employee go to the doctor or hospital?

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

**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?

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

\_\_\_\_\_  
Date