

INCIDENT REVIEW FORM

Injury _____ Illness _____ Near Miss _____

Member Name: _____

Injured Employee Name: _____

Age: _____

Employee Works: Reg. FT _____ Reg. PT _____ Seasonal _____ Temporary _____ Volunteer _____

of Months w/Employer: _____ # of Months Doing this Job _____

Date of Incident: _____

Time of Incident: _____

Location of Incident: _____

Date and Time Incident Reported to Supervisor: _____

Witness Names and Phone Numbers: _____

If incident was a motor vehicle accident, form MV 104a must be attached.

Incident narrative – Attach separate employee and witness statements of the entire incident and events leading up to the incident. Make sure they are dated and signed by each individual. Attach pictures of the location of incident/accident & any contributing risk factors (if available).

If vehicle/equipment was involved, specify type: _____

Specific body parts injured (check all that apply and use the highlighter tool to indicate R/L/Both):

Head		Ear	R/L/Both	Finger	R/L	Leg	R/L/Both
Neck		Shoulder	R/L/Both	Chest		Knee	R/L/Both
Face		Arm	R/L/Both	Back		Ankle	R/L/Both
Eye	R/L/Both	Elbow	R/L/Both	Hip	R/L/Both	Foot	R/L/Both
Nose		Wrist	R/L/Both	Buttocks	R/L/Both	Toe	
Mouth		Hand	R/L/Both	Groin		Internal Organ	

Other: _____

Describe incident in detail (including tasks being performed prior to incident and what caused incident to occur):

Initial treatment: (enter name of facility and check facility type):

Name of Facility:	<input type="checkbox"/>	Urgent Care	<input type="checkbox"/>
None	<input type="checkbox"/>	Occupational Medical Clinic	<input type="checkbox"/>
First Aid Only	<input type="checkbox"/>	Emergency Room	<input type="checkbox"/>
Primary Care Physician	<input type="checkbox"/>	Other:	<input type="checkbox"/>

ROOT CAUSE

Motor Vehicle Accident		Electrical	
Fall From Different Level (Elevation)		Slip, Trip, Fall on Same Level	
Object Handled		Occupational Exposure	
Human/Animal/Vector		Striking Against or Stepping On	
Caught in/under/between		Struck by	

CONTRIBUTING FACTORS

Please select all that apply

Environmental			
Workplace			

PERSON COMPLETING REPORT AND CHECK LIST

Name: _____ Title: _____

Signature: _____ Date: _____

INCIDENT REVIEW & ANALYSIS

Utilize information collected on the incident review form to complete root cause analysis and outline steps to be taken to avoid future incidents

Items to be Reviewed and Discussed:	Action Item	Assigned To	Completed Date
1. Engineering controls			
2. Management controls			
3. Personal protective equipment			
4. Improvement strategies = 5 P's			
a. Policies			
b. Programs			
c. Plans			
d. Processes			
e. Procedures			
5. Interim measures			
a. Temporary fix			
b. Permanent resolution with a final target			
6. Take corrective action (attach documentation highlighting preventive actions to be taken).			
7. Follow up evaluation once all actions completed to ensure prevention of incident occurring again.			
8. Employer review/change of procedures with re-instruction to all employees.			
9. Reviews and sign off via chain of command of member entity.			
10. File this completed incident analysis report & attachments with PERMA for their review.			
11. Conduct quarterly and annual review of all your incidents.			

Signature of all managers and top leadership:

Employee's Direct Supervisor		Date	
Department Head		Date	
Safety Coordinator		Date	
Principal Executive Officer		Date	