EDMONDS COMMUNITY COLLEGE

Injury and Illness Incident Report

Attention: This form contains information relating to injured person's health and must be used in a manner that protects the confidentiality of the information to the extent possible while being used for occupational safety and health purposes.

Complete this form for all injuries and illnesses within 24 hours. When complete, print form, get necessary signatures, and make two photocopies. Forward the original to Security Office and forward a photocopy to the Human Resources Departmant. The affected person keeps the remaining photocopy.

INFORMATION ABOUT THE INJURED PERSON

FULL NAME _____ **SID** _____

STREET _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHONE _____ **EMAIL** _____

DATE OF BIRTH _____ ◯ **MALE** ◯ **FEMALE**

◯ **STUDENT** ◯ **VISITOR** ◯ **EMPLOYEE** **JOB TITLE** _____

HRS/DAY _____ **DAYS/WEEK** _____ **DEPARTMENT** _____

INFORMATION ABOUT THE CASE

DATE OF INJURY OR ILLNESS _____ **TIME OF EVENT** _____ ◯ **AM** ◯ **PM**

TIME INJURED PERSON'S SHIFT STARTED _____ ◯ **AM** ◯ **PM** **LOCATION (BUILDING/ROOM)** _____

What was the injured person doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the injured person was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."

What happened? Tell us how the injury occurred. Examples: "When the ladder slipped on wet floor, worker fell 20 feet"; "worker was sprayed with chlorine when gasket broke during replacement"; or "worker developed soreness of wrist over time."

What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back"; "chemical burn, hand"; or "carpal tunnel syndrome."

What object or substance directly harmed the injured person? Examples: "concrete floor"; "chlorine"; "radial arm saw". If this question does not apply to the incident, leave it blank.

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INFORMATION ABOUT THE MEDICAL TREATMENT

EXTENT OF TREATMENT: ◯ NONE ◯ FIRST AID ◯ MEDICAL TREATMENT

IF TREATMENT WAS GIVEN AWAY FROM THE WORK SITE, WHERE WAS IT GIVEN?

DR. NAME _____ **FACILITY** _____

STREET _____ **CITY** _____ **STATE** _____ **ZIP** _____

WAS THE INJURED PERSON TREATED IN AN EMERGENCY ROOM? ◯ YES ◯ NO

WAS THE INJURED PERSON HOSPITALIZED AS AN INPATIENT? ◯ YES ◯ NO

SIGNATURES

WITNESS _____ **CONTACT PHONE** _____

INJURED PERSON'S SIGNATURE _____

SUPERVISOR NAME _____ **PHONE** _____

SUPERVISOR SIGNATURE _____ **DATE** _____

FOR HUMAN RESOURCES OFFICE USE ONLY

L&I CLAIM RECORDABLE? ◯ YES ◯ NO **If the injured person died, date of death** _____

DID INJURED PERSON FILE A LABOR & INDUSTRIES REPORT? ◯ YES ◯ NO **CLAIM #** _____

DATE HIRED _____ **CASE # FROM LOG** _____

DATES LOST FROM WORK _____ **TO** _____

DATES ON RESTRICTED DUTY _____ **TO** _____

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