West Shore Community College
EMPLOYEE INJURY / INCIDENT REPORT

1.Employee Name		2. Injury Date	3. Date Reported
4. Street Address		5. Time of Injury	6. Exact Location
7. City		8. Phone Number	9. Social Security Number
10. State	11. ZIP	12. Date of Hire	13. Date of Birth

14. **Describe incident specifically** (What you were doing, location, condition of area, objects, equipment, personal protection equipment, & persons involved)

Witness(es):

15. Name	15a. Phone Number	15b. Address
16. Name	16a. Phone Number	16b. Address
17. Name	17a. Phone Number	17b. Address

18. **Incident / Injury Type (Must select one)**

__ Acid/Chemicals
__ Allergic Reaction
__ Bruise/contusion
__ Burn/scald
__ Cut/laceration/abrasion
__ Exposure to Blood/body fluids
__ Exposure to Communicable disease
__ Fracture/break/dislocation
__ Hernia
__ Infection symptoms
___ Multiple Injuries
___ Needlestick – clean
___ Needlestick - dirty
___ No apparent injury
___ Pain/soreness
___ Puncture (non-needle)
___ Rash/skin reaction
___ Strain/sprain
___ Swollen
___ Other_____

19. **Part of Body (Include ALL Affected body parts)**

__ Abdomen
__ Ankle – ( )L ( )R
__ Arm – ( )L ( )R
__ Back
__ Buttocks
__ Cardiovascular/heart
__ Chest
__ Ear – ( )L ( )R
__ Elbow – ( )L ( )R
__ Entire Body
__ Eye – ( )L ( )R
__ Foot/toes – ( )L ( )R
__ Groin
___ Hand/finger – ( )L ( )R
specify_____
___ Head/face
___ Hip/pelvis
___ Knee – ( )L ( )R
___ Leg – ( )L ( )R
___ Lungs/pulmonary
___ Neck
___ Nose
___ Shoulder
___ Wrist – ( )L ( )R
___ Other_____

20. **ACCIDENT CAUSE (Must select one)**

__ Burn or Scald – Chemical Contact
__ Burn or Scald – Electrical Contact
__ Burn or Scald – Temperature Contact
__ Caught in, under or between
__ Cut/Puncture/Scrape
__ Needlestick
__ Fall, Slip, or Trip – different level
__ Fall, Slip, or Trip – same level
__ Faint/Pass Out
__ Infectious Disease
__ Inhalation
__ Motor Vehicle
__ Bending
__ Lifting
__ Pushing or Pulling
__ Reaching
__ Explosion or Flare Back
__ Falling or Flying Object
__ Struck by/against
__ Other_____

21. Lost Work Time? ___ No ___ Yes	22. If so, date last worked	23. Date returned to work: _____ Light Duty _____Regular Duty

24. Initial Medical Treatment
___ None Required ___ Refused ___ First Aid Only ___Physician/Clinic ___ ER

SUGGESTIONS OR ACTIONS TAKEN TO PREVENT REOCCURRENCE

Submitted By: **Date:**

**Return completed form to Debbie Campbell or Jessica Keith in Human Resources