STATE OF DELAWARE

INJURY/ILLNESS REPORT

____
(Agency Name)

Human Resources Use Only
Time Loss ☐ *Yes* ☐ *No*
Return Date _______________
Alternate Duty ☐ *Yes* ☐ *No*
Alternate Duty Location _____________
Date of Hire _______________
Date to PMA ______________
W/C approved ____________

Employee   Visitor   Volunteer

Name: ________________________________   Gender: ☐ Male ☐ Female

Address: ________________________________   Class Title: ________________________________

________________________________   Work Area: ________________________________

Phone: ________________________________   Shift: ________________________________

Employee Please fill out this form completely, filling in all spaces.

The purpose of this report is to ensure that complete and accurate information is obtained as to the cause and type of injury/illness experienced. This information will be used to ensure fair and equitable treatment of the injured employee. It will also be used to aid in the prevention of future injuries of the same nature.

Date/Time of Injury: ______________________   Location of Injury: ______________________
Building/Room Number

Did Injury occur while on duty ☐ Yes ☐ No Did you leave duty ☐ Yes ☐ No Date left duty ____________

Supervisor Notified: ______________________   Date/Time Notified: ______________________

Body part(s) affected: ________________________________ ☐ Left ☐ Right ☐ Multiple

What job duties were you performing when the injury happened? ________________________________

____

How did the injury happen?____

____

____

____

____

____

In your opinion what actually caused the Injury? ________________________________

____

What factors contributed to this injury? ________________________________

____

How would you prevent this injury from occurring in the future? ________________________

____

____

What protective clothing was worn? ________________________________

What protective equipment was used? ________________________________

Witnesses: ____

Employee Signature: ______________________________   Date: ______________________

ACCIDENT INVESTIGATION REPORT

(to be completed by supervisor upon notification of injury)

☐ Information on front of form verified ☐ Witnesses interviewed ☐ Statements attached

I. Class of Injury (check all that apply):

☐ No medical treatment requested/required
☐ First Aid
☐ Medical treatment (ambulance)
☐ Employee left duty
☐ Other: ____________________

II. Nature of Injury or Illness:

Description of injury or illness: ____________________

____

Body part(s) affected (be specific, i.e. – right index finger): ____________________

____________________ ☐ Left ☐ Right ☐ Multiple

III. Causes (check all that apply):

☐ Safety Violation (self or others)
☐ Faulty Equipment
☐ Environmental Conditions
☐ Resident Care
☐ Resident Aggression
☐ Work Hazard (repetitive motion, vibration, exposure, etc.)
☐ Accident (trips, slips, falls, etc.)
☐ Lifting
☐ Other: ____________________
☐ Recurrence
☐ Transportation

IV. Corrective Measures:

Summary of interview with injured employee: ____________________

____

What do you consider to be the root cause of this incident? ____________________

____

What steps will be taken to prevent future occurrence? ____________________

____

____________________ ☐ Training required ☐ Repair/replace

____________________ ____________________
Supervisor's Signature Date

(To be filled out by Safety Champion)

☐ Further investigation warranted? Who should address? ____________________

How should it be addressed? ____________________

____

☐ Inform/communicate (i.e. e-mail, memo, etc.) ☐ Improve systems (i.e. work order, etc.) ☐ Documentation attached

____________________ ____________________
Signature of Safety Champion Date