

INCIDENT / NEAR MISS REPORT



THIS form is to be completed immediately following:

- Incident = An event causing injury or property damage**
- Near Miss = An unsafe act or condition → includes confrontations/threats**

FULL NAME OF PERSON(S) INVOLVED		DATE OF INCIDENT	TIME OF INCIDENT <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE REPORTED
JOB TITLE/DEPARTMENT (ONLY IF EMPLOYEE)			SHIFT START TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	HIRE DATE
18 OR OVER <input type="checkbox"/> YES <input type="checkbox"/> NO	ADDRESS	PHONE	NAME OF FAMILY MEMBER OR GUARDIAN (IF NECESSARY) PHONE:	
PROGRAM/EVENT				
LOCATION OF INCIDENT/NEAR MISS			PERSON INCIDENT WAS REPORTED TO	
EXTENT OF INJURY <input type="checkbox"/> NO INJURY <input type="checkbox"/> FIRST AID ONLY <input type="checkbox"/> TAKEN TO CLINIC <input type="checkbox"/> TAKEN TO ER <input type="checkbox"/> APPT MADE				TREATING MEDICAL FACILITY
DESCRIPTION OF INCIDENT/NEAR MISS				
BODY PART INJURED (BE SPECIFIC)				
STAFF ACTIONS (CONTINUE ON BACK IF NECESSARY)				
ANY WITNESSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME/PHONE	NAME/PHONE	
WERE THERE OTHERS INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME/PHONE	NAME/PHONE	
WAS THERE PHYSICAL DAMAGE?				
CAUSE OF INCIDENT/NEAR MISS				
REPORT COMPLETED BY		SIGNATURE	DATE	
<i>If the injured person is an employee, his/her supervisor must be contacted and a report must be filed with WSI no later than the next business day. Please check which report is to be completed:</i> <input type="checkbox"/> WSI Incident Report (if not seeking medical attention), or <input type="checkbox"/> First Report of Injury (if seeking medical attention)				

Please forward to supervisor/manager to complete the following:

ROOT CAUSE ANALYSIS - CONTRIBUTING INCIDENT FACTORS		
PHYSICAL <input type="checkbox"/> POOR HOUSEKEEPING <input type="checkbox"/> POOR OR NO EQUIPMENT GUARDING <input type="checkbox"/> IMPROPER ILLUMINATION <input type="checkbox"/> IMPROPER VENTILATION <input type="checkbox"/> EQUIPMENT FAILURE <input type="checkbox"/> UNSAFE APPAREL <input type="checkbox"/> MEDICAL CONDITION (STROKE, CARDIAC ARREST) <input type="checkbox"/> SURROUNDING SUBCONTRACTOR AT FAULT <input type="checkbox"/> CONDITIONS (WET, ICY) _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> OTHER _____	BEHAVIORAL <input type="checkbox"/> NOT USING REQUIRED PPE <input type="checkbox"/> PERFORMING DUTIES OUTSIDE SCOPE OF JOB <input type="checkbox"/> FAILURE TO OBEY SUPERVISOR'S INSTRUCTIONS <input type="checkbox"/> FAILURE TO OBEY JOB PROCEDURES <input type="checkbox"/> SUSPECTED INTOXICATION <input type="checkbox"/> PERSON WAS ENGAGED IN HORSEPLAY <input type="checkbox"/> PERSON WAS UNSUITED FOR THE JOB <input type="checkbox"/> OTHER _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> OTHER _____	PROCEDURAL <input type="checkbox"/> ASKED TO PERFORM JOB WITHOUT TRAINING <input type="checkbox"/> OPERATING EQUIPMENT WITHOUT TRAINING <input type="checkbox"/> POOR ENFORCEMENT OF PPE USE <input type="checkbox"/> NEEDED EQUIPMENT NOT SUPPLIED <input type="checkbox"/> FAILURE TO INSPECT EQUIPMENT <input type="checkbox"/> FAILURE TO CORRECT POOR PROCEDURES <input type="checkbox"/> WRONG EQUIPMENT FOR THE OPERATION <input type="checkbox"/> WRONG CHEMICAL OR OTHER USED <input type="checkbox"/> NO PRE-SITE INSPECTION <input type="checkbox"/> OTHER _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> OTHER _____
FOLLOW-UP (CONTACT THE INJURED PERSON OR FAMILY ON INJURED PERSON'S CONDITION)		DATE
STATUS OF INJURED PERSON		PERSON WHO MADE CONTACT
CORRECTIVE ACTION		DATE COMPLETED
SUPERVISOR SIGNATURE		DATE
SAFETY MANAGER SIGNATURE		DATE