

APPENDIX 715-A

EMPLOYEE'S REPORT OF INJURY INCIDENT

Eau Claire County 721 Oxford Avenue Ste 1122 Eau Claire, WI 54703-5481

Instructions: An injury/illness or incident must be reported immediately to the employee's supervisor. This form must be completed as soon as possible, filed with your immediate supervisor, and returned to the Human Resources Department within 48-hours of the incident. If the employee is unable to complete his/her account of the event, the supervisor is to provide the information on their behalf.

Employee Contact Info

Employee Name (First, Middle, Last) PLEASE PRINT		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Employee Home Telephone No.	
Employee Street Address			City		State
Zip Code		Department		Supervisor	
Birth Date	Position	Date of Hire (if known)			

Description of Incident (Completion of each question is required)

Date of Injury/Incident	Time AM/PM	Date Injury/Incident was Reported	Time AM/PM	Where did incident occur?
What work was being performed at the time?			Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Name(s) of Witnesses:	
			A. Phone #	B. Phone #
What happened to cause this injury/illness or incident? Describe how the injury or incident occurred - give details about tools, machinery, objects, chemicals, other persons, environmental conditions, etc. that were involved in or caused the injury/incident.				

IF AN INJURY/ILLNESS INCIDENT

What type of injury/illness was this (Ex: Cut, strain, burn, contusion [bruise or sore], infection, etc.)?

What body part was injured?

Did you seek medical treatment?

No - This injury required only first aid care on the scene or at home.

Yes at _____ &/or _____
Name of Clinic or Hospital Name of treating healthcare provider if known

Date & Time: _____

Briefly explain the care your injury needed:

Will you need more care? No Yes Unknown Explain:

Have you missed work? No Yes Starting when: Ending when:

Please remember to obtain and submit healthcare provider's report of status to your supervisor prior to returning to work.

Incident Prevention

How do you think this incident could have been prevented?

Did you find the safety equipment, procedures, & PPE to be sufficient? Yes No If not, explain:

What corrective action have you taken to prevent this from re-occurring?

Signature

Employee:	Work Contact No.	Position	Date Signed
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SUPERVISOR MUST COMPLETE OPPOSITE SIDE BEFORE SUBMITTAL TO HUMAN RESOURCES

SUPERVISOR'S REVIEW OF INCIDENT

Classification of Incident

Employee Date of Incident Date Employer Notified
Department: Position: Supervisor:
Injury: ___ Lost time/Last Day Worked:_____ ___ Medical care only incident ___ First aid only

Incident Review

SUPERVISORS: Please make note of any corrections or additions to Employee report:

What factors do you think contributed to this incident?

- Q. Was this a routine or non-routine/unusual task for this worker?
Was proper technique applied? If no, explain:
Were the tools, equipment, & assistance appropriate and sufficient for this worker & job?
Were the written rules, directives, warnings, and oral instructions appropriate & sufficient for the task?
Were work conditions underestimated, overlooked, or not inspected before task was started?
Was the worker inattentive or did the worker show disregard for rules or hazardous conditions?
Was there poor communication or planning with other workers?
Were safety devices [guards, locks, seatbelts, etc.] in use?
Was required PPE worn?
Circle all protection that was in use: ear eye head/face foot hand high visibility vest other

Explain all other factors & unusual conditions which may have contributed to this incident:

IF AN INJURY - How would you classify this experience: Injury was a result of

- [] slip/trip/all [] struck-by/hitting [] caught-in/on/between [] bug/plant/weather-environmental contact [] vehicular accident
[] use of excessive muscular force [] contact with chemical [] altercation with subject [] patient care [] other

How would you classify this incident: AVOIDABLE UNAVOIDABLE

Remediation Plan

What corrective action has been taken?

What else do you think the dept needs to do IMMEDIATELY to prevent this from re-occurring? Check all that apply. Add to list if needed

- More training for the division/department workgroup worker
More supervision is planned for this employee
Purchase different tools or equipment. Explain:
Modify or reassign task, work conditions or tools, or work directives. Explain:
Other:

What long-range recommendations do you think the dept needs to implement?

Signatures

Supervisor: Date: Dept/Div Head: Date:

1. SEND COMPLETED ORIGINAL REPORT TO HUMAN RESOURCES WITHIN 48 HOURS