HENRY M. JACKSON FOUNDATION
FOR THE ADVANCEMENT OF MILITARY MEDICINE

OSH504E
160907

Advancing Military Medical Research

Employee Incident Report

Please complete and send to the HJF Corporate Occupational Safety and Health (OSH) Program within 48 hours, by fax (240) 694-3132 or by email safety@hjf.org. Copies must also be provided to local host-site and HJF safety offices as required by local polices. Questions may be addressed to the HJF Corporate OSH Program at (240) 694-4050. Attach additional sheets as necessary.

Name: (Please provide middle initial)	Work Phone Number:
Job Title:	Work Email Address:
Work Location (Room #, Bldg #, Installation Name):	Work Mailing Address:
Supervisor's Name:	Supervisor's Work Phone Number:
Supervisor's Title:	Supervisor's Email Address:
Date of Accident:	Time of Accident:

What time did you begin your shift on the day of incident?

What are your regularly scheduled...
Hours: Days:

Where did the incident occur? (Be specific: Bldg #, floor, room #, etc.):

What were you doing immediately before the incident?

Describe how the incident occurred (provide specific details):

Were safeguards and/or personal protective equipment (PPE) provided? Yes No Were they used? Yes No	Describe safeguards and/or PPE being used at the time of the incident.

Select the type of injury from the table to the right. Check all that apply; circle the primary injury if more than one is checked.

If the injury is not listed in the table, please describe here:

Check all that apply	
	Fall
	Needle Puncture
	Exposure
	Sprain/Strain
	Burn
	Bite
	Contusion
	Laceration/Cut
	Eye Injury
	Rash

Indicate body part affected. Check all that apply.

Fingers: **R** ☐ **L** ☐ Which finger? 1☐ 2☐ 3☐ 4☐ 5☐
Toes: **R** ☐ **L** ☐ Which toe? 1☐ 2☐ 3☐ 4☐ 5☐

	Check all that apply
☐	Head
☐	Face
☐	Neck
☐	Chest
☐	Stomach
☐	Groin
☐	Coccyx (Tail Bone)
☐	Lower Back
☐	Upper Back

	R	**L**
Ear	☐	☐
Eye	☐	☐
Shoulder	☐	☐
Arm	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand	☐	☐
Hip	☐	☐
Leg	☐	☐
Knee	☐	☐
Ankle	☐	☐
Foot	☐	☐

Did you seek medical assistance? ☐ Yes ☐ No *If yes, complete the following*.

Name of individual providing treatment:

Name of facility providing treatment:

Full address of facility/provider (please include street, city, state and zip code):

Provider's phone number:

Outcome of medical evaluation:

Returned to work; DATE:

Light duty/restricted duty; Number of days:

Unable to return to work; Number of days:

Witnesses (List names and a phone number for each):

Name: Work Phone:

Name: Work Phone:

Name: Work Phone:

What should or could have been done to prevent the incident, in your opinion?

Additional comments:

Employee's Signature Date

TO BE COMPLETED BY HJF SAFETY MANAGER – DO NOT WRITE BELOW THIS LINE		
Safety Manager Signature:	Date Notified of Accident:	Date form received: