



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: <small>(Please provide middle initial)</small>	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:	<table border="1"> <thead> <tr> <th colspan="2">Check all that apply</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td>Fall</td></tr> <tr><td><input type="checkbox"/></td><td>Needle Puncture</td></tr> <tr><td><input type="checkbox"/></td><td>Exposure</td></tr> <tr><td><input type="checkbox"/></td><td>Sprain/Strain</td></tr> <tr><td><input type="checkbox"/></td><td>Burn</td></tr> <tr><td><input type="checkbox"/></td><td>Bite</td></tr> <tr><td><input type="checkbox"/></td><td>Contusion</td></tr> <tr><td><input type="checkbox"/></td><td>Laceration/Cut</td></tr> <tr><td><input type="checkbox"/></td><td>Eye Injury</td></tr> <tr><td><input type="checkbox"/></td><td>Rash</td></tr> </tbody> </table>	Check all that apply		<input type="checkbox"/>	Fall	<input type="checkbox"/>	Needle Puncture	<input type="checkbox"/>	Exposure	<input type="checkbox"/>	Sprain/Strain	<input type="checkbox"/>	Burn	<input type="checkbox"/>	Bite	<input type="checkbox"/>	Contusion	<input type="checkbox"/>	Laceration/Cut	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	Rash
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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	
<input type="checkbox"/>	Head
<input type="checkbox"/>	Face
<input type="checkbox"/>	Neck
<input type="checkbox"/>	Chest
<input type="checkbox"/>	Stomach
<input type="checkbox"/>	Groin
<input type="checkbox"/>	Coccyx (Tail Bone)
<input type="checkbox"/>	Lower Back
<input type="checkbox"/>	Upper Back

	R	L
Ear	<input type="checkbox"/>	<input type="checkbox"/>
Eye	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Hand	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>
Leg	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>



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

By submitting this form you acknowledge HJF's Privacy Notice — <https://www.hjf.org/resources/privacy-notice/>

TO BE COMPLETED BY HJF SAFETY MANAGER – DO NOT WRITE BELOW THIS LINE

Safety Manager Signature:

Date Notified of Accident:

Date form received: