Accident/Incident Report Form

Instructions: 1) Injured/involved person or supervisor completes Part A. 2) Send completed form to EH&S Office at MS#48 within 24 hours of accident/incident. 3) EH&S Office will complete Part B, retain copy of report, and if necessary forward completed report form to Human Resources for evaluation by Workers’ Compensation program. 4) Call EH&S Office (x3347) with questions.

Part A: To be completed by injured/involved person and/or supervisor.

Name of the injured/involved person: __________________________ Phone number: __________________________

Department: __________________________ Job title: __________________________

Supervisor’s name: __________________________

Location of accident/incident: __________________________ Building: __________________________ Room: __________________________

Date and time of accident/incident: __________________________ How long into shift? __________________________

Treatment administered: □ None □ First Aid □ Doctor □ Hospital

Missed time: □ Yes □ No If yes, duration: __________________________

Person(s) completing report: __________________________

What was the person(s) doing just prior to accident?

________________________________________________________________________

Description of the accident/incident (nature of injury, body part involved, etc)?

________________________________________________________________________

Contributing causes (hazardous condition, faulty equipment, lack of training, etc)?

________________________________________________________________________

How could the accident/incident have been prevented?

________________________________________________________________________

Actions taken to prevent reoccurrence?

________________________________________________________________________

Name of witnesses?

________________________________________

Attach any additional information and any witness statements to this report.

Signature of person(s) completing report __________________________ Date signed __________________________

Part B: To be completed by EH&S Office.

Report to Human Resources(Y/N, Date transmitted):

Accident/incident investigation information (investigator’s name, attach investigation report if completed):

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