GOSHEN COLLEGE

Human Resources Office
1700 South Main Street
Goshen, IN 46256
574.535.7314

Injury and Illness Incident Report

(completed by employee & supervisor together)

This form must be submitted to Human Resources within 24 hours
(hand-deliver to HR Office, scan/email to hr@goshen.edu, or fax to x7319)

Employee name: _____

Date of Birth: _____/_____/_____ Home/personal phone: _____

Home address: _____

❑Female ❑Male Job Title: _____ Date Hired: _____

Date of injury/illness: _____/_____/_____ Time of injury/illness: _____

What time did the employee begin work on the day of the injury/illness: _____

Where did the injury/illness occur? _____

Will/did the injury/illness cause loss of time at work (other than medical treatment)? ❑Yes ❑No

If yes, when is the employee expected to return to work? _____

Names of witnesses: _____

What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Examples: "climbing a ladder while carrying roofing materials";"spraying chlorine from hand sprayer"; "daily computer key-entry."

What happened? Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

What was the injury or illness? What part of the body was affected and how was it affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

Attach additional sheet if necessary

Did the injured employee seek medical treatment? ❑Yes ❑No

Name of health care professional _____

Name of medical facility _____

If yes, what kind of treatment?
- ❑ Minor medical treatment by employee
- ❑ Minor medical treatment by clinic
- ❑ Emergency room
- ❑ Hospitalization for more than 24 hours

_____ _____ _____

Employee Signature *Supervisor Signature* *Date*

Investigation to be completed by Safety Committee
(Not employee or direct supervisor)

Contributing factors to the accident/injury/illness:

_____

_____

_____

_____

Root cause (after 5 "Whys?" ... on average, 5 iterations of asking "Why?"):

_____

_____

_____

Specific corrective action(s) to prevent reoccurrence:

_____

_____

_____

_____

Plans to implement corrective actions (who, what, when, costs, etc.):

_____

_____

_____

_____

_____ _____

Safety Committee Member *Date*

Human Resources use only

Employee SSN: _____ Claim #: _____ OSHA Recordable? ❑Yes ❑No