

Injury & Incident Reporting and Investigation Form

*****Form should be completed by Supervisor & Injured Worker and returned to Landrum within 7 days as per OSHA*****

**Immediately report injuries to 850-476-5100 and send form to Fax 850-478-4088 or wclaims@landrumhr.com.
Keep a copy for your records.**

INJURED WORKER				Case #:	
Injured Worker's Full Name:	Worker's Job Title:	Injured Worker's Address & Phone #:	Date of Hire:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Date of Incident: (mo/day/yr)	Time of Incident: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date of Report: (mo/day/yr)	Time Employee Began Work: ____ A.M. ____ P.M.	Where did the event occur?	
What was the Injury/Illness and the body part(s) injured?		***Fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____		Name & Address of Treating Dr. / Facility:	
Treatment: <input type="checkbox"/> Employee Does NOT Elect Medical Treatment at this time <input type="checkbox"/> On Site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Emergency Room <input type="checkbox"/> Admitted to Hospital***					

WITNESSES AND/OR WITNESS STATEMENT

Witnesses Name and Contact Information (Phone #): _____ Witness statement attached? ☐ Yes ☐ No

THE INCIDENT (Use Back of Sheet if Needed, and Reference Below)

Describe what happened. (Investigate scene of incident or conditions. Describe events prior to incident, who was involved, when and where the incident happened, what happened, and how.)

What was the employee doing just before the incident occurred? (Describe the activity and how employee was hurt.)

What object or substance directly harmed the employee? (ex: concrete floor, chlorine, radial arm saw)

SUPERVISOR CONTACT INFORMATION

Reporting Supervisor/Investigator Name: _____ Location: _____ Phone Number: _____

Why did it happen? (Root Cause Analysis) (What was the root cause of the incident, i.e., actually caused the illness, injury, or incident?)

Unsafe Acts	Potential Contributing Factors	Potential Management System Opportunities
<input type="checkbox"/> Improper Work Technique	<input type="checkbox"/> Poor Workstation Design or Layout	<input type="checkbox"/> Lack of Written Procedures or Safety Rules
<input type="checkbox"/> Improper PPE, Not Used or Used Incorrectly	<input type="checkbox"/> Fire or Explosion Hazard	<input type="checkbox"/> Safety Rules Not Enforced
<input type="checkbox"/> Safety Rule Violation	<input type="checkbox"/> Congested Work Area	<input type="checkbox"/> Hazards Not Identified
<input type="checkbox"/> Operating Without Authorization	<input type="checkbox"/> Hazardous Substances	<input type="checkbox"/> PPE Unavailable
<input type="checkbox"/> Failure to Warn or Secure	<input type="checkbox"/> Inadequate Ventilation	<input type="checkbox"/> Insufficient Worker Training
<input type="checkbox"/> Operating at Improper Speeds	<input type="checkbox"/> Improper Material Storage	<input type="checkbox"/> Insufficient Supervisor Training
<input type="checkbox"/> By-Passing Safety Devices	<input type="checkbox"/> Improper Tool or Equipment	<input type="checkbox"/> Improper Maintenance
<input type="checkbox"/> Guards Not Used	<input type="checkbox"/> Insufficient Job Knowledge	<input type="checkbox"/> Inadequate Supervision
<input type="checkbox"/> Improper Loading or Placement	<input type="checkbox"/> Slippery Conditions	<input type="checkbox"/> Insufficient Job Planning
<input type="checkbox"/> Improper Lifting	<input type="checkbox"/> Poor Housekeeping	<input type="checkbox"/> Inadequate Hiring Practices
<input type="checkbox"/> Servicing or Adjusting Machinery in Motion	<input type="checkbox"/> Excessive Noise	<input type="checkbox"/> Poor Process Design
<input type="checkbox"/> Horseplay	<input type="checkbox"/> Inadequate Guarding of Hazards	<input type="checkbox"/> Inadequate Workplace Inspections
<input type="checkbox"/> Drug or Alcohol Use	<input type="checkbox"/> Defective Tools/Equipment	<input type="checkbox"/> Inadequate Equipment
<input type="checkbox"/> Unsafe Act(s) of Others	<input type="checkbox"/> Insufficient Lighting	<input type="checkbox"/> Unsafe Design or Construction
<input type="checkbox"/> Unnecessary Haste	<input type="checkbox"/> Inadequate Fall Protection	<input type="checkbox"/> Unrealistic Scheduling
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

What should be done or has been done to prevent a recurrence of this injury?

*****OSHA requires you, the worksite employer, to report to OSHA at 1-800-321-6742 or www.osha.gov/report.html the following: Fatalities within 8 hrs; Amputations, loss of eye, & in-patient hospitalizations within 24 hrs. Contact Landrum immediately for any of these conditions.**

Signature of Supervisor	Print Name & Title	Date
Signature of Injured Worker	Print Name & Title	Date