XXXX Area POD Plan

**INCIDENT REPORT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | An incident is an event that caused injury to a person or damage to equipment, facilities, or materials. | | | | | | | | | | | | | | | |
|  | A near miss is an event that potentially could have caused injury to a person or damage to equipment, facilities, or materials. | | | | | | | | | | | | | | | |
| Form completed by: | | | | | | | | Person involved in incident: | | | | | | | | |
| Witness(es): | | | | | | | | | | | | | | | | |
| Employee's occupation: | | | | | | | | | | | | | | | | |
| Date of incident: | | Time of incident: | | | | | | A.M. | | P.M. | | | Date reported: | | | |
| Department and location where incident occurred: | | | | | | | | | | | | | | | | |
| Worker's shift on day of injury, from: | | | | | | A.M. | | P.M. | | | to: | | | A.M. | | P.M. |
| Nature of injury (such as strain, cut, or bruise): | | | | | | | | | | | | | | | | |
| Body parts affected (such as left hand or right ankle): | | | | | | | | | | | | | | | | |
| Medical treatment required: | | | None | | First aid/Med express | | | | | | | Hospital or physician | | | | |
| Name of hospital or attending physician: | | | | | | | | | | | | | | | | |
| Was employee hospitalized overnight as a patient? | | | | | | | | | Yes | | | | | | No | |
| Did employee leave work because of the injury? | | | | Yes | No | | If yes, what time: | | | | | | | A.M. | | P.M. |
| Date employee returned to regular duty: | | | | | | Date employee returned with light-duty restrictions: | | | | | | | | | | |
| Describe incident fully (use back of sheet if necessary, or sketch on back of sheet if needed to clarify): | | | | | | | | | | | | | | | | |
| List all equipment, machinery, materials, or chemicals employee was using when incident occurred: | | | | | | | | | | | | | | | | |
| Identify factors you believe contributed to or caused the incident: | | | | | | | | | | | | | | | | |

**INCIDENT REPORT (CONTINUED)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Complete this section if an injury occurred or equipment was damaged.** | | | | | |
| Were proper procedures being followed when incident occurred? | Yes | | | No | |
| If no, explain: | | | | | |
| Was employee wearing proper personal protective equipment? | N/A | | Yes | | No |
| If no, explain: | | | | | |
| Are changes in equipment necessary to prevent recurrence? | Yes | | | No | |
| If yes, explain: | | | | | |
| Employee signature: | | Date: | | | |
| Supervisor signature: | | Date: | | | |

Please forward this form to the Clinic Safety Officer as soon as possible following the incident or near miss.

Note: If an employee or volunteer receives medical treatment from a hospital or physician, additional forms need to be filled out and forwarded to the Clinic Safety Officer along with the incident report so that a workers’ compensation claim can be filed.

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| --- | --- | --- | --- | --- |
| **Safety Officer --- Send copies to:** | Documentation Tracking Unit |  |  |  |