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.

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