|  |  |  |
| --- | --- | --- |
| **MIT** | **Accident / Injury / Illness****Investigation Report** | Page 1 of 3 |
|  |
| **1.0 Employee / Injured Person Information**  |
| Name (First, MI, Last):      | Address:           |
| E-mail / Phone Number:      | Job Title:      | Full time or Part Time (circle one)Shift: [ ] 1st [ ] 2nd [ ] 3rd |
| Employee’s date of birth:      | Employee’s date of hire:       | Department Name:      |
| Building / Facility / Area:      | Location of Incident:      |
| Does injured party work for an outside contractor or agency? (Yes / No)Did incident occur on Employer premises? (Yes / No) Did the incident occur during overtime? (Yes / No)  | Male [ ]  Female [ ]  |
| **Supervisor Information:** Name (First, MI, Last)      | Supervisor Employee No.      | Supervisor Telephone No.      |

|  |
| --- |
| **2.0 Accident / Injury Information** |
| Date of Incident:      | Time of Incident:      | To whom was the injury reported to? Position of person reported to: | Date reported:      | Time Reported:       |
| Was performing normal job duties: [ ]  Yes [ ]  No  | If No, Explain:       |
| Witness Names: | 1.       | 2.       | 3.       |
| Type of Incident:: [ ]  Injury [ ]  Property Damage [ ]  Near Miss [ ]  Fire [ ]  Environmental Release |

|  |
| --- |
| **3.0 Accident / Injury Categories:**  |
| [ ]  Struck by or against | What was the employee doing before the incident occurred?:(tools equipment or materials being used) |
| [ ]  Slip/Trip/Fall  |
| [ ]  Fall from elevation  |
| [ ]  Caught in or between  |
| [ ]  Lifting |
| [ ]  Repetitive motion |
| [ ]  Pushing/Pulling |
| [ ]  Other Bodily motion | What happened to cause injury or illness? |
| [ ]  Chemical exposure |
| [ ]  Physical agent  |
| [ ]  Burn |
| [ ]  Cut by |
| [ ]  Motor vehicle |
| [ ]  Other (describe) |
| Name the object or substance which directly injured employee: (Example: machine or object he struck against or which struck employee; vapor or poison inhaled or swallowed; in cases of strains, etc., object employee was lifting, pulling, etc..) |
| **4.0 Injury Types / Body Parts:** (Check one from each column)  |
| [ ]  Sprain/Strain | [ ]  Eye |
| [ ]  Bruise / Contusion | [ ]  Head |
| [ ]  Cut/Laceration/Abrasion  | [ ]  Neck |
| [ ]  Amputation/Crush  | [ ]  Arm/Elbow/Shoulder |
| [ ]  Repetitive Stress Injury | [ ]  Hand/Finger/Wrist |
| [ ]  Burn [ ]  Thermal [ ]  Chemical | [ ]  Back |
| [ ]  Hernia | [ ]  Trunk |
| [ ]  Fracture | [ ]  Leg/Knee/Ankle |
| [ ]  Foreign Body | [ ]  Foot/Toes |
| [ ]  Pain  | [ ]  Body Systems |
| [ ]  Skin Disorder | [ ]  Lung / respiratory system |
| [ ]  Multiple Injury | [ ]  Multiple Body Parts |
| [ ]  Other | [ ]  Other |
| Comments / Additional Information:       | Comments / Additional Information:       |
| If additional documentation is available, please check box and note reference.[ ]        |

|  |
| --- |
| **5.0 - Describe the Facts of What Happened:** (Include machine, tool, task, object, or substance involved. Be specific regarding what, when, where, andhow the incident occurred)**.** Attach supporting documentation as necessary - photos, procedures, etc |
|       |

What are the normal working hours and days for the employee?

What time did the employee start work on the day of the incident?

Did employee return to work with no lost time? (Yes / No)

Did the employee return to work with restricted duty? (Yes/No)

Is this a re-occurrence of a previous injury? (Yes / No)

If yes, when did original injury occur?

Did employee seek medical attention? (Yes / No)

If yes, what is the name of the facility?

Was the employee treated in the emergency room? (Yes / No)

Was the employee transported by ambulance? (Yes/No)

Was the employee hospitalized overnight? (Yes / No)

Note: If employee seeks medical attention for this incident after this form is submitted, you must notify MIT's Workers Compensation Administrator (x3-9496) and OSHA Recordkeeper (x8-5638)