

**Eastern Nazarene College  
Accident/Incident Report Form**

*Complete within 24 hours AND send to Director of Risk Management  
This side to be completed by the employee, student, or visitor*

<b>PART 1: INFORMATION ABOUT THE PERSON INVOLVED IN THE INCIDENT</b>			
Full Name			<b>GENDER:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Address		City, State, Zip	<b>DATE OF BIRTH:</b>
<b>EMPLOYEE:</b> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> <b>STUDENT:</b> <input type="checkbox"/> <b>VISITOR:</b> <input type="checkbox"/> <b>VENDOR:</b> <input type="checkbox"/>		Home/Cell Phone	Work Phone
ADDITIONAL EMPLOYEE INFORMATION:			
Job Title		Department	Supervisor Name
<b>PART 2: DESCRIPTION OF THE ACCIDENT/INCIDENT/DAMAGE</b>			
Date of Accident/Incident	Time of Accident/Incident AM <input type="checkbox"/> PM <input type="checkbox"/>	Temperature	Weather at time of Accident/Incident Dry <input type="checkbox"/> Rainy <input type="checkbox"/> Snowy <input type="checkbox"/> Icy <input type="checkbox"/> Sunny <input type="checkbox"/> Cloudy <input type="checkbox"/> Other <input type="checkbox"/>
Location of Accident/Incident (Address, or Building Name, Room Number)			Police/Fire/EMS Notified Yes <input type="checkbox"/> No <input type="checkbox"/>
Result in Injury or Property Damage No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes →	Description of Injury/Illness/Property Damage:		
<b>PART 3: ACCIDENT/INCIDENT PROPERTY DAMAGE DETAILS</b>			
Specific task being performed at time of Accident/Incident:			
Step-by-step events leading up to the Accident/Incident:			
Equipment/tools involved: Materials being handled:			
Unusual condition(s):			
Other relevant details:			
Were there other Witnesses to the Accident/Incident: No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes →	Witness Names and Contact Information:		
Medical Evaluation: Conducted By: <input type="checkbox"/> Campus Nurse <input type="checkbox"/> Police/Fire/EMS <input type="checkbox"/> Hospital Emergency Room <input type="checkbox"/> Other: <input type="checkbox"/> Deemed unnecessary by patient	Date of initial medical evaluation: Name of treating facility:		
Print Name and Signature of reporter*		Date	

*\*Signing of this form does not constitute acceptance of individual fault*

**ENC Representative or Supervisor to complete other side**

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**PART 4: ADDITIONAL ACCIDENT/INCIDENT/DAMAGE INFORMATION**

*Supervisor or College Representative Comments: (Additional information on nature of accident/incident, damage details, etc.)*

**PART 5: POSSIBLE CAUSAL FACTORS**

*Process/environment related (Check all that possibly apply)*

- |  |   |
|--|---|
| <input type="checkbox"/> Housekeeping                | <input type="checkbox"/> Workstation/area setup       |
| <input type="checkbox"/> Work procedure or lack of   | <input type="checkbox"/> Condition of flooring/ground |
| <input type="checkbox"/> Repetitive motion           | <input type="checkbox"/> Lighting or lack of          |
| <input type="checkbox"/> Tool/equipment availability | <input type="checkbox"/> Ventilation                  |
| <input type="checkbox"/> Tool/equipment condition    | <input type="checkbox"/> Weather                      |
| <input type="checkbox"/> PPE Availability            | <input type="checkbox"/> Other                        |

*Personnel related (Check all that possibly apply)*

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Tool/equipment use or selection    | <input type="checkbox"/> Work pacing |
| <input type="checkbox"/> Level of support/assistance        | <input type="checkbox"/> Other       |
| <input type="checkbox"/> Awkward posture(s)                 |                                      |
| <input type="checkbox"/> PPE use or lack of                 |                                      |
| <input type="checkbox"/> Level of attention to task         |                                      |
| <input type="checkbox"/> Following of procedure/instruction |                                      |

**PART 6: POSSIBLE ROOT CAUSE(S):** *Factors contributing to the workplace condition(s)/act(s) identified above*

*(Check all that possibly apply)*

- Awareness of job hazards
- Level of training
- Level of inspection/maintenance
- Level of communication
- Level of resources available
- Other:

*Additional details on possible cause(s):*

**PART 7: PLANNED FOLLOW-UP EFFORTS**

*Describe follow-up effort to be undertaken. As actions are completed record completion date, and initial of supervisor responsible for completion of follow-up*

<i>Description of Planned Action</i>	<i>Date Completed</i>	<i>Supervisor Initial</i>

<i>Signature of Supervisor*</i>	<i>Date</i>
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<i>Signature of responsible Vice President*</i>	<i>Date</i>
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**Employee, Student or Visitor to complete other side**