**SELF REPORT  
OF INJURY FORM**

INSTRUCTIONS Using this form, everyone shall report all accidents, injuries, illnesses, or unplanned events which could have resulted in an injury or illness. Once completed, this form shall be given to a shed committee member for next steps.

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| --- | --- | --- | --- | --- | --- | --- |
| I AM REPORTING A WORK RELATED: |  | INJURY |  | ILLNESS |  | NEAR MISS |

|  |  |  |  |
| --- | --- | --- | --- |
| YOUR NAME | Managers NAME | | DATE OF REPORT |
|  |  |  | |
| JOB TITLE | Has your supervisor been made aware of this incident? | | |
|  |  | | |

|  |  |  |
| --- | --- | --- |
| LOCATION OF INCIDENT | DATE OF INCIDENT | TIME |
|  |  |  |
| WITNESSES *if any* | | |
|  | | |
| INCIDENT DESCRIPTION Describe tasks being performed and sequence of events. *Attach additional pages as necessary.* | | |
|  | | |
| What could nave been done to prevent this injury / near miss? | | |
|  | | |
| What parts of your body were injured? If a near miss, how could you have been hurt? | | |
|  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Was medical treatment necessary? | | | | IF YES, NAME OF HOSPITAL / PHYSICIAN: |
|  | YES |  | NO |  |
| DATE OF VISIT | | TIME OF VISIT | | HOSPITAL / PHYSICIAN PHONE |
|  | |  | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Has this part of your body been injured before? |  | YES |  | NO | If YES, when? |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you have other employment? |  | YES |  | NO | Company Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YOUR SIGNATURE** | **DATE** | **SUPERVISOR SIGNATURE** | **DATE** |
|  |  |  |  |