**Incident/Near Miss Report (sample)**

* INJURY INCIDENT: Caused injury to a person
* DAMAGE INCIDENT: Caused damage to equipment/building/materials, vehicle, etc.
* NEAR MISS: Could have caused injury/damage to people/equipment/other.

**GENERAL INFORMATION SECTION**

Person completing form: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of incident: \_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_ AM/PM

Department/location where occurred: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name/Job Title of employee(s) involved in the incident/near miss:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s shift on day of incident: (from)\_\_\_\_\_\_\_\_\_ AM/PM (to) **\_\_\_\_\_\_\_** AM/PM

**EMPLOYEEE INJURY SECTION – For Near Misses, skip to next section**

Nature of the injury (strain, cut, bruise, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body part(s) affected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical treatment required? 🞏 YES 🞏 NO

If yes, what type? 🞏 First aid on-site 🞏 Express care 🞏 Doctor 🞏 Hospital

Name of provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the employee hospitalized overnight as a patient? 🞏 YES 🞏 NO

Did employee leave work early due to injury? 🞏 NO 🞏 YES - What time? **\_\_\_\_\_\_\_** AM/PM

Date the employee returned to regular duty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (or N/A)

Date returned with light duty restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (or N/A)

**INCIDENT DESCRIPTION SECTION**

Witness(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the incident fully: (use back page if necessary or sketch on back if needed to clarify):

List all equipment, machinery, materials or chemicals the employee was using when the event occurred (use back page if necessary):

Identify the factors that you believe contributed to or caused the incident:

Were proper procedures being followed when the incident occurred? 🞏 YES 🞏 NO

If NO, explain:

Was employee wearing proper personal protective equipment? 🞏 YES 🞏 NO 🞏 N/A

If NO, explain:

Are changes in equipment necessary to prevent reoccurrence? 🞏 YES 🞏 NO

If YES, explain:

Employee signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Supervisor name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Supervisor signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Send form to [HR Rep/Email] as soon as possible after incident. If employee visits medical provider and requires treatment, include Workers’ Compensation required paperwork.