

CONFIDENTIAL
Wake Forest University
First Report of Incident

Employee Information		
Name of Injured Employee:		<input type="checkbox"/> Male <input type="checkbox"/> Female
Job Title:	Department:	
Employee Home Address (street, city, state, zip):		Home Phone #:
SSN:	Date of Birth:	WFU Hire Date:
Wage/Salary Info (HR to complete):		Hrs/Days Worked per Week: /
Incident Information		
<input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Vehicle Accident (If vehicle accident, also complete Form ?)		
Date of Incident:	Date Incident Reported:	
Did the incident result in lost workdays? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list dates:		
Was employee interviewed by supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervisor's Name:	
Date of Interview:	Were Witnesses Present? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name(s) of Witness(es):		
Were other employees involved in the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name(s) of Other Employee(s):		
Was first aid administered at WFU? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	By Whom?
Was EMS dispatched? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was employee sent to hospital/clinic for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital/Clinic where employee was sent:		Authorized By:
Did employee receive Rx for injury/illness?		Treating Physician:
Description of Incident		
What time did employee begin work?	What time did incident occur?	
Where did injury/illness/vehicle accident occur? (include building, room#, area of campus)		
What was employee doing before injury/illness/vehicle accident occurred? (Please be specific)		
How did the injury/illness/vehicle accident occur? (Please be specific)		

For Supervisor: Circle all appropriate words or statements with regard to the injury/illness/accident:

Unsafe Acts/Conditions	Injury Type	Job Factors	Type of Accident
<input type="checkbox"/> Operating without authority <input type="checkbox"/> Failure to secure area <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Inactivating safety devices <input type="checkbox"/> Using equipment improperly <input type="checkbox"/> Improper loading/placement <input type="checkbox"/> Improper lifting <input type="checkbox"/> Servicing equipment in motion <input type="checkbox"/> Horseplay <input type="checkbox"/> Failure to use PPE <input type="checkbox"/> Failure to follow procedure <input type="checkbox"/> Inadequate guards/protection <input type="checkbox"/> Defective equipment/material <input type="checkbox"/> Inadequate work space <input type="checkbox"/> Inadequate ventilation <input type="checkbox"/> Unsafe personal attire <input type="checkbox"/> Hazardous environmental conditions <input type="checkbox"/> Unexpected movement/hazards <input type="checkbox"/> Hazardous placement or storage <input type="checkbox"/> Fire/explosion hazard <input type="checkbox"/> Other:	<input type="checkbox"/> Abrasion <input type="checkbox"/> Burn: Chemical <input type="checkbox"/> Burn: Thermal <input type="checkbox"/> Contusion <input type="checkbox"/> Fracture <input type="checkbox"/> Inhalation <input type="checkbox"/> Irritation <input type="checkbox"/> Insect Bite <input type="checkbox"/> Laceration <input type="checkbox"/> Shock <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Other:	<input type="checkbox"/> Body reaction <input type="checkbox"/> Caught between <input type="checkbox"/> Caught under <input type="checkbox"/> Contact with chemicals <input type="checkbox"/> Contact with cold <input type="checkbox"/> Contact with electricity <input type="checkbox"/> Contact with heat <input type="checkbox"/> Fall, different level <input type="checkbox"/> Slip/trip <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	<input type="checkbox"/> Fall, same level <input type="checkbox"/> Inhalation <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Overexertion <input type="checkbox"/> Push/Pull <input type="checkbox"/> Repetitive motion <input type="checkbox"/> Rubbed/abrasion <input type="checkbox"/> Slip/Trip <input type="checkbox"/> Struck Against <input type="checkbox"/> Struck by <input type="checkbox"/> Other:

Agency	Task Being Performed	Circle All Injured Body Parts	
<input type="checkbox"/> Chemicals <input type="checkbox"/> Conveyors <input type="checkbox"/> Feeding material <input type="checkbox"/> Glass <input type="checkbox"/> Glue <input type="checkbox"/> Grating <input type="checkbox"/> Knife/razor <input type="checkbox"/> Ladders <input type="checkbox"/> Machine/Equipment <input type="checkbox"/> Pallets <input type="checkbox"/> Surfaces <input type="checkbox"/> Tools <input type="checkbox"/> Vehicles <input type="checkbox"/> Other:	<input type="checkbox"/> Adjusting <input type="checkbox"/> Carrying <input type="checkbox"/> Cleaning <input type="checkbox"/> Lifting <input type="checkbox"/> Operating <input type="checkbox"/> Pushing/Pulling <input type="checkbox"/> Servicing <input type="checkbox"/> Unjamming <input type="checkbox"/> Walking <input type="checkbox"/> Other:	Eye R L Foot R L Hand R L Wrist R L Hip R L Knee R L Leg R L Ankle R L Shoulder R L Ear R L Skin Head Back Chest Finger (describe) Face Other:	

Use the space below for any information which would help to explain the incident: (Example: Safety Suggestion)

Supervisor Comments:

Employee Comments:

Employee Signature: _____ **Date:** _____ **Phone:** _____

Print Employee Name: _____

Supervisor Signature: _____ **Date:** _____ **Phone:** _____

Print Supervisor Name: _____

Forward to Human Resources (Employee Relations) Phone: 758-4945 Fax: 758-6127