GENERAL ACCIDENT/CHEMICAL EXPOSURE INCIDENT REPORT FORM

Date this form was completed on: _____

Date of Accident: _____ Date of Exposure: _____

Name of person completing this form:

_____

Person involved in accident/exposure: _____

Social Security # _____ (optional)

Description of the ( ) Accident ( ) Injury ( ) Exposure:

_____

_____

_____

Nature of ( ) Accident ( ) Injury ( ) Exposure:

_____

_____

Was any medical or other service beyond basic first aid needed because of the ( ) Accident ( ) Injury ( ) Exposure? Yes___ No___ Were days lost from work? Yes ___ No ___

If Yes, describe - What? Where? By Who?

_____

_____

_____

Who, if anyone, witnessed the ( ) Accident ( ) Injury ( ) Exposure?

_____

What, in your opinion, attributed to the cause of the Accident/Exposure?

_____

_____

_____

What, if anything, <u>can</u> be done to prevent this type of accident from occurring again?

_____

_____

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Has corrective action been taken to prevent this problem in the future? Explain.

_____

_____

Had safety training been offered to the employee that could have prevented this?

_____

Are safety policies found in the OSHA manual on this problem? ____ yes ____ no

If problem was a chemical exposure - was the SDS available? ____ yes ____ no

I have read this report and found the facts to be accurate and true.

Employee signature: _____ Date: _____

The individual above was referred to _____ for medical follow-up on _____ (date).

Report was received from this health care provider on _____ (date).

Follow up treatment has been recommended ____ yes ____ no.

Attach any medical reports from the health care provider above to this form and keep in the employees file.

* This form will be kept in addition to separate forms which may be needed for Federal (OSHA) or State occupational safety regulations, and/or State workmen's compensation requirements.