Injury Report & Investigation Form

To be completed by the employee's supervisor or other responsible administrative official.

Incident Tracking Number:

Complete and submit this form to the HR Office no later than the next working day after the accident. Copy to file.

*Only fields relevant to the injury need to be completed

Incident Information				
Day		Date		Time
Location				
Related or Affected Department				
Employer Notified	Date		Time	
Supervisor Notified	Date		Time	

Subject's Relationship to the University Mark all that apply ☑

Employee	Faculty	Full Time
PhilaU Student	Administrator	Part Time
Visitor / Guest	Support Staff	Casual
Other	Student Worker	

Subject's Information

Name		Male / Female	DOB	ID#
Residence	Contact		Employer *	PhilaU / Other
Street	Telephone, Home			
	Telephone, Mobile / Cell			
City	e-mail, Home		Telephone, Work	
State / Zip Code	Other		e-mail, Work	

* If PhilaU employee note Department, Supervisor & Job Title.

Injury / Illness Information N/A

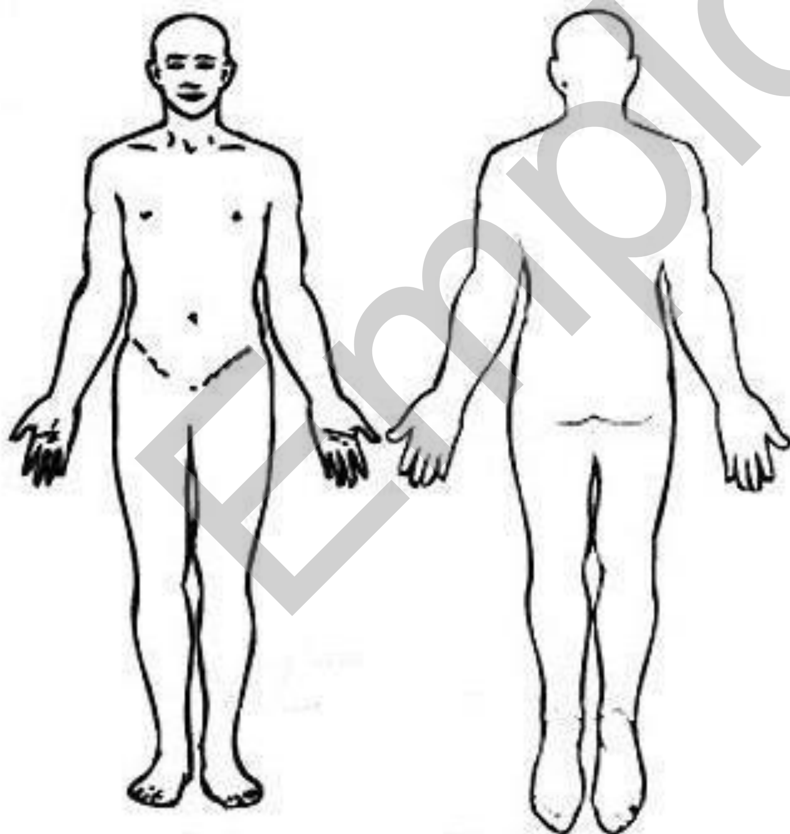
Nature of Injury Mark all that apply ☑

Hearing Loss	Abrasion	Contusion	Fracture
Poisoning	Amputation	Cut-laceration	Hernia
Respiratory Condition	Bruise	Death/Fatality	Infection
	Burn, chemical	Dermatitis	Needle stick
Skin Disorder	Burn, thermal	Dislocation	Puncture wound
Other Illness	Concussion	Electrical shock	Sprain / Strain
Other Injury	Carpal tunnel	Eye injury	

Body Part(s) Injured Mark all that apply ☑

Abdomen	Eye	Hip	Shoulder
Ankle	Finger	Knee	Skin
Arm, upper	Foot	Leg	Thigh
Back	Forearm	Lungs	Thumb
Chest	Groin	Multiple	Toe
Ear	Hand	Neck	Wrist
Elbow	Head	Other	

Mark diagram at location of injury



Right hand and forearm

Left hand and forearm

Employee

Treatment Mark all that apply ☑				*If Subject is deceased, date of death:			
N/A Not needed		No Medical Care on scene		Treated on Scene by DPS		Clinic / Hospital	
Requested by Subject		Self Care on scene		Treated on Scene by EMS		University Health Center	
Recommended		First Aid provided on scene		Transported by Self		Panel Physician	
Provided		Non-Emergency care		Transported by DPS		Subject's Physician	
Refused by Subject		Emergency Medical care		Transported by EMS		Emergency Department	
If other, describe?							

Returned to Duty		Y		N	Est. Date of Return		Y		N	Restricted Duty		Y		N	Est. Duration	
Notes & Comments																

Incident Information Review ☑

Discuss the accident with the employee involved and with any witnesses. Be sure to question the why, what, where, when, who, how, and any other aspects of the accident.

								Date							Date	
Subject Interviewed		Y		N		N/A	Date		Incident Information Corroborated		Y		N	Date	
Department Head Contacted		Y		N		N/A	Date		Recommendations Made		Y		N	Date	
Supervisor Interviewed		Y		N		N/A	Date		**Incident Investigation Closed**		Y		N	Date	
Witness(s) Interviewed		Y		N		N/A	Date		**Supplemental Invest Suggested**		Y		N	Date	
Notes & Comments															

Training & Safety Review ☑	Standard Operating Procedures – SOP's Personal Protective Equipment – PPE														
SOP's for Activity In-place		Y		N		N/A	SOP's Known to Subject		Y		N	SOP's Followed		Y		N
Special Training Needed		Y		N		N/A	Training Provided		Y		N	Training Received		Y		N
Safety Equipment In-place		Y		N		N/A	Safety Equipment Used		Y		N	Safety Equipment Disabled		Y		N
PPE for Activity Needed		Y		N		N/A	PPE Available		Y		N	PPE Used		Y		N
Notes & Comments																

Incident Location & Equipment Condition Review ☑

Appropriate Work Area		Y		N		N/A	Safe Work Area		Y		N	Safe Working Conditions		Y		N
Appropriate Equipment		Y		N		N/A	Equipment in Good Condition		Y		N	Equipment used as Intended		Y		N
Notes & Comments																

Activity & Experience Review ☑

Activity within Assigned Duties		Y		N		N/A	Activity within Training & Experience		Y		N		N/A	Yrs. of Service	
Activity Assigned by Supervisor		Y		N		N/A	Activity Assigned by							Yrs. Experience	
Notes & Comments															

Investigators Comments	

Recommended Corrective Actions by Department Head Attach additional pages as needed

Person Completing this Report **(Name & Title, Contact Telephone Number)**		Date Completed:

Health & Safety Committee Investigator **(Name & Title, Contact Telephone Number)**		
		Date Completed

Employee

Forward Report to Jefferson Human Resources