

ACCIDENT REPORT

Accident Report Number: _____

1) Contact Appropriate Director Immediately:
For FMS – Bill Friedel (315-404-3742)
For ES – Frank Castellano (315-292-2933)
For L&M – Gary Kline (315-525-3630)

2) Within 24 hours, the responding supervisor is to fill out the form and email report to: accidentreports@htcorp.net

SECTION A - TO BE COMPLETED BY RESPONDING SUPERVISOR

Employee Not an Employee

Name: _____ Gender: M F Date of Birth: _____

Telephone #: _____ Time Shift Starts: _____ AM PM

Title: _____ Dept: _____ Supervisor: _____

Scheduled Work Days: M T W TH F SA SU Schedule: FT PT

Date of Accident: _____ Time of Accident: _____ AM PM

Day of Week: M T W TH F SA SU

Accident Location Address: _____

Exact Area where accident occurred: _____

Witnesses?

Name(s): _____

Describe what happened and to who (brief summary):

Responding Supervisor: _____

Date of report: _____ Time of report: _____ AM PM

SECTION B - TO BE COMPLETED BY INVESTIGATOR:

Type of Injury (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Slip/Fall | <input type="checkbox"/> Push/Pull |
| <input type="checkbox"/> Contusion (Bruise) | <input type="checkbox"/> Lift/Lower |
| <input type="checkbox"/> Needle Puncture | <input type="checkbox"/> Fumes/Dust/Gas/Caustic/Noise |
| <input type="checkbox"/> Laceration (Cut) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sprain/Strain | Explain: _____ |

Describe what happened (who, what, when, where) in detail:

Body Part(s) Affected: _____

Front View		Back View					
Head	<input type="checkbox"/> R <input type="checkbox"/> L	Eye	<input type="checkbox"/> R <input type="checkbox"/> L	Head	<input type="checkbox"/> R <input type="checkbox"/> L		
Forehead	<input type="checkbox"/> R <input type="checkbox"/> L	Cheek	<input type="checkbox"/> R <input type="checkbox"/> L	Ear	<input type="checkbox"/> R <input type="checkbox"/> L		
Temple	<input type="checkbox"/> R <input type="checkbox"/> L	Nose	<input type="checkbox"/> R <input type="checkbox"/> L	Neck	<input type="checkbox"/> R <input type="checkbox"/> L		
Ear	<input type="checkbox"/> R <input type="checkbox"/> L	Mouth	<input type="checkbox"/> R <input type="checkbox"/> L	Trunk	<input type="checkbox"/> R <input type="checkbox"/> L		
Neck	<input type="checkbox"/> R <input type="checkbox"/> L	Lip	<input type="checkbox"/> R <input type="checkbox"/> L	Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L		
Trunk	<input type="checkbox"/> R <input type="checkbox"/> L	Jaw	<input type="checkbox"/> R <input type="checkbox"/> L	Upper Arm	<input type="checkbox"/> R <input type="checkbox"/> L		
Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	Chin	<input type="checkbox"/> R <input type="checkbox"/> L	Elbow	<input type="checkbox"/> R <input type="checkbox"/> L		
Upper Arm	<input type="checkbox"/> R <input type="checkbox"/> L	Chest	<input type="checkbox"/> R <input type="checkbox"/> L	Forearm	<input type="checkbox"/> R <input type="checkbox"/> L		
Elbow	<input type="checkbox"/> R <input type="checkbox"/> L	Abdomen	<input type="checkbox"/> R <input type="checkbox"/> L	Wrist	<input type="checkbox"/> R <input type="checkbox"/> L	Buttocks	<input type="checkbox"/> R <input type="checkbox"/> L
Forearm	<input type="checkbox"/> R <input type="checkbox"/> L	Genitalia	<input type="checkbox"/> R <input type="checkbox"/> L	Hand	<input type="checkbox"/> R <input type="checkbox"/> L	Thigh	<input type="checkbox"/> R <input type="checkbox"/> L
Wrist	<input type="checkbox"/> R <input type="checkbox"/> L	Thigh	<input type="checkbox"/> R <input type="checkbox"/> L	Thumb	<input type="checkbox"/> R <input type="checkbox"/> L	Leg	<input type="checkbox"/> R <input type="checkbox"/> L
Hand	<input type="checkbox"/> R <input type="checkbox"/> L	Leg	<input type="checkbox"/> R <input type="checkbox"/> L	Finger	<input type="checkbox"/> R <input type="checkbox"/> L	Foot	<input type="checkbox"/> R <input type="checkbox"/> L
Thumb	<input type="checkbox"/> R <input type="checkbox"/> L	Knee	<input type="checkbox"/> R <input type="checkbox"/> L	1	<input type="checkbox"/> R <input type="checkbox"/> L	Ankle	<input type="checkbox"/> R <input type="checkbox"/> L
Finger	<input type="checkbox"/> R <input type="checkbox"/> L	Foot	<input type="checkbox"/> R <input type="checkbox"/> L	2	<input type="checkbox"/> R <input type="checkbox"/> L	Toe	<input type="checkbox"/> R <input type="checkbox"/> L
1	<input type="checkbox"/> R <input type="checkbox"/> L	Ankle	<input type="checkbox"/> R <input type="checkbox"/> L	3	<input type="checkbox"/> R <input type="checkbox"/> L		
2	<input type="checkbox"/> R <input type="checkbox"/> L	Toe	<input type="checkbox"/> R <input type="checkbox"/> L	4	<input type="checkbox"/> R <input type="checkbox"/> L		
3	<input type="checkbox"/> R <input type="checkbox"/> L			5	<input type="checkbox"/> R <input type="checkbox"/> L		
4	<input type="checkbox"/> R <input type="checkbox"/> L						

Were there any environmental circumstances that contributed to the accident, such as, lighting, water on floor, space limitations? If yes, explain. Yes No

Were there any physical objects or machine/equipment involved in accident? If yes, provide which object, machine/equipment and any exposures, improper use or defect in object, machine/equipment.

Did individual leave work to seek medical treatment? Yes No

If yes, how transported? _____ By whom? _____

Was First Aid provided? Yes No

If yes, what and by whom? _____

Were Safety Data Sheets (SDS) consulted for treatment information? Yes No

Recommendation:

What was Root Cause of accident?

What corrective action was taken?

What additional actions need to be taken to prevent this from happening again in the future?

Date preventative action to be completed: _____

SECTION C – SIGNATURES

Investigator Signature: _____ **Date:** _____

Employee signature: _____ **Date:** _____