Clear Form

ACCIDENT REPORT

HUMAN TECHNOLOGIES
The Power of People with Purpose

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

Email Accident Report

SECTION B - TO BE COMPLETED BY INVESTIGATOR:

Type of Injury *(check all that apply)*

☐ Slip/Fall
☐ Contusion (Bruise)
☐ Needle Puncture
☐ Laceration (Cut)
☐ Sprain/Strain
☐ Push/Pull
☐ Lift/Lower
☐ Fumes/Dust/Gas/Caustic/Noise
☐ Other
Explain: _____

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

_____

_____

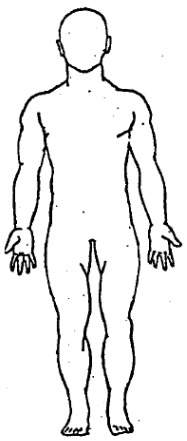
_____

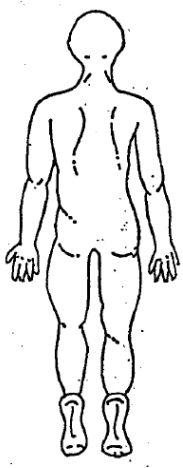
_____

REVISION DATE: 12152021

Body Part(s) Affected: _____

Head	☐R ☐L	**Front View**		Eye	☐R ☐L	Head	☐R ☐L	**Back View**		Buttocks	☐R ☐L
Forehead	☐R ☐L			Cheek	☐R ☐L	Ear	☐R ☐L			Thigh	☐R ☐L
Temple	☐R ☐L			Nose	☐R ☐L	Neck	☐R ☐L			Leg	☐R ☐L
Ear	☐R ☐L			Mouth	☐R ☐L	Trunk	☐R ☐L			Foot	☐R ☐L
Neck	☐R ☐L			Lip	☐R ☐L	Shoulder	☐R ☐L			Ankle	☐R ☐L
Trunk	☐R ☐L			Jaw	☐R ☐L	Upper Arm	☐R ☐L			Toe	1☐R ☐L
Shoulder	☐R ☐L			Chin	☐R ☐L	Elbow	☐R ☐L				2☐R ☐L
Upper Arm	☐R ☐L			Chest	☐R ☐L	Forearm	☐R ☐L				3☐R ☐L
Elbow	☐R ☐L			Abdomen	☐R ☐L	Wrist	☐R ☐L				4☐R ☐L
Forearm	☐R ☐L			Genitalia	☐R ☐L	Hand	☐R ☐L				5☐R ☐L
Wrist	☐R ☐L			Thigh	☐R ☐L	Thumb	☐R ☐L				
Hand	☐R ☐L			Leg	☐R ☐L	Finger	1☐R ☐L				
Thumb	☐R ☐L			Knee	☐R ☐L		2☐R ☐L				
Finger	1☐R ☐L			Foot	☐R ☐L		3☐R ☐L				
	2☐R ☐L			Ankle	☐R ☐L		4☐R ☐L				
	3☐R ☐L			Toe	1☐R ☐L						
	4☐R ☐L				2☐R ☐L						
					3☐R ☐L						
					4☐R ☐L						
					5☐R ☐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: _____

REVISION DATE: 12152021