

# ACCIDENT REPORT

Accident Report Number: \_\_\_\_\_

1) Contact the Director of Corporate Safety immediately following an accident.  
Rick Swift (315) 520-9084

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	Head	<input type="checkbox"/> R <input type="checkbox"/> L
Forehead	<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	Neck	<input type="checkbox"/> R <input type="checkbox"/> L
Ear	<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	Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L
Trunk	<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	Elbow	<input type="checkbox"/> R <input type="checkbox"/> L
Upper Arm	<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	Wrist	<input type="checkbox"/> R <input type="checkbox"/> L
Forearm	<input type="checkbox"/> R <input type="checkbox"/> L	Hand	<input type="checkbox"/> R <input type="checkbox"/> L
Wrist	<input type="checkbox"/> R <input type="checkbox"/> L	Thumb	<input type="checkbox"/> R <input type="checkbox"/> L
Hand	<input type="checkbox"/> R <input type="checkbox"/> L	Finger	1 <input type="checkbox"/> R <input type="checkbox"/> L
Thumb	<input type="checkbox"/> R <input type="checkbox"/> L		2 <input type="checkbox"/> R <input type="checkbox"/> L
Finger	1 <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		4 <input type="checkbox"/> R <input type="checkbox"/> L
	3 <input type="checkbox"/> R <input type="checkbox"/> L		
	4 <input type="checkbox"/> R <input type="checkbox"/> L		
	5 <input type="checkbox"/> R <input type="checkbox"/> L		
			Buttocks <input type="checkbox"/> R <input type="checkbox"/> L
			Thigh <input type="checkbox"/> R <input type="checkbox"/> L
			Leg <input type="checkbox"/> R <input type="checkbox"/> L
			Foot <input type="checkbox"/> R <input type="checkbox"/> L
			Ankle <input type="checkbox"/> R <input type="checkbox"/> L
			Toe
			1 <input type="checkbox"/> R <input type="checkbox"/> L
			2 <input type="checkbox"/> R <input type="checkbox"/> L
			3 <input type="checkbox"/> R <input type="checkbox"/> L
			4 <input type="checkbox"/> R <input type="checkbox"/> L
			5 <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: \_\_\_\_\_