Bowdoin College Accident/Incident Investigation Form — Employee Report

EMPLOYEE INFORMATION					
Employees must report any accident/incident to their supervisor immediately, and complete a written statement in support of					
their report. Please fill in the following as completely as possible. You must contact Human Resources (x3837) prior to					
obtaining voluntary outside medical attention.					
Employee Name:					
Address:					
City:					
State & Zip:					
Phone #:	DOB:		■ Male ■ Female		
GENERAL ACCIDENT INVESTIGATION					
Name of individual completing the report:					
Date of accident/incident:	Time of accident:	Shift:	Overtime: Y/N		
Supervisor's Name:					
Date you reported the incident to your supe		Time:			
When was supervisor notified? □ Immediately □ Later Explain:					
Witness(es)? (*witnesses must also complete a written statement – attach to this document)					
Describe location where accident/incident	occurred:				
Describe work being performed during accident/incident:					
TT 1 1 1 C · .1	1 2				
How long have you been performing these duties?					
Was work within normal ish duties?					
Was work within normal job duties?					
Do you work for any other employers? Y/1	N If was placed list.				
Do you work for any other employers: 17 1	ii yes, picase list.				
ACCIDENT INVESTIGATION					
Contributing factors: Human error	Unsafe conditions	r 🗖 Equipment	☐ Other		
Explain:					
Type of equipment, tool, vehicle, etc. involved:					
Was the right tool or equipment (e.g. safety	ralgeege Keylar alouge haaring pr	otection etc.) heine	rused for the job?		
was the light tool of equipment (e.g. safety	glasses, Reviai gloves, ficaring pr	otection, etc.) being	, used for the job:		

ACCIDENT INVESTIGATION (CONTINUED)				
Part of body: Employees involved: Activity being performed:	Please describe the incident?	e incident to the best of your ability.	What were you doing at the time of the	
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Do you have any suggestions	to prevent this type	of accident from recurring?		
Do you have any suggestions	to prevent this type	or accident from recurring.		
Do you have any discomfort?	Y/N Please describ	be the type of discomfort you are feel	ling:	
Please identify the area in which injury and any areas where you a Specify front or back.		If your injury is serious and you require emergency medical treatment, contact SECURITY (x3500) and emergency medical transport will be arranged for you. If the accident/incident involved chemical exposure, a copy of the MSDS sheet must be provided to the hospital.		
	Nes.	All employees have the right to se second opinion after 10 days from	e their own physician and/or obtain an the date of the incident.	
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Individual completing repo	ort (signature):		Date:	