



NORTH CAROLINA EMPLOYEE INCIDENT REPORT

Instructions: Employee must complete report. If more room is needed, continue in a Word document and attach it to this submission.

Employees are required to complete this form for all incidents and near hits. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

Supervisor Review: If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report.

My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Check Not applicable (employee completed form) or sign below if you assisted with the completion of this form.

Supervisor Name: _____ Signature: _____

Employee Information		Date/Location Information	
Name (Full):		Date of Incident: / /	Time of Day:
Employee ID #:		Date Reported to Supervisor: / /	Time of Day:
Job Title:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Work Address:	
Telephone #:			
Department:	Incident Location (address, Building name, office, cross streets, fire name, woods, facility, room #, etc.):		
Agency/University:			
Supervisor:			
Date Hired:	Time in Current Job:	County:	

Witness Information

Were there any witnesses to the incident? Yes No Number of Witnesses (if applicable): _____

If yes, list all known witnesses/ phone #'s below, please include additional names on attachment if needed.

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Medical Information

Part(s) of the body injured:

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? Yes No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

Description of Accident/Incident

Suggested Corrective Actions



NORTH CAROLINA SUPERVISOR INCIDENT INVESTIGATION REPORT

Instructions: Begin investigation within 24 hours and attach the Employee Incident Report and Witness Reports to this report. Forward all reports within 72 hours to the Program Administrator. If more room is needed, continue in a Word document and attach it to this submission.

Agency/ University:	Date of Incident:
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Employee Name:	Employee Phone #:
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Incident Supervisor:	Supervisor Phone #:
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Incident Classifications (check all that apply)

Near Hit Injury Fatality Property Damage Spill Possible Blood Borne Pathogen exposure

Employee required:

First-Aid Only Medical treatment and released Hospitalized Other:

Employee:

Returned to work no restrictions Returned to work with restrictions Did not return to work (Lost Days)

Hazard Types (select one based on origination of injury in this preference order)

Violence or injuries caused by people or animals Transportation Fires or Explosions
 Slips, Trips, Falls Surface Level Fall from Elevation Exposure to harmful substances or environment
 Contact with objects or equipment (Struck By, Struck Against, Caught-on, Caught between, Puncture, Cut) Over-Exertion (lifting)
 Bodily Motion (reaching, twisting, running) Other (List Here):

Names of Witnesses Interviewed:

Incident Information

Describe the specific activity the employee was engaged in and the sequence of events. Include objects or substances that directly injured or made the employee ill. Describe tools, equipment, and PPE in use. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)

Is the activity part of the employee's normal job? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior to beginning activity, did the employee review potential hazards/dangers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date employee last received training for the activity. / /
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What was the root cause of the incident? Ask why then ask why again (e.g. Why? The employee slipped on scrap metal. Why? The work area was not cleaned up. Why? The employee was rushing to get a project done and did not take time to clean up the work area.)

Action taken or will be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.

Supervisor's Name:	Signature	Date of Report: / /
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Manager's Name:	Signature	Date Reviewed: / /
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The Supervisor will obtain the Managers' signature and forward signed copies of the Employee Report, Witness Statements, and the Supervisor's report to the Program Administrator. The Program Administrator will send the Employee's and Supervisor's reports to the Manager's supervisor, Local Safety Contact, Safety Committee Chairperson, and Agency Safety Director within two business days. The WCA will receive all reports and all supporting documentation.

Program Administrator Name:	Signature	Date / /
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Date Corrective Actions Completed:



ACCIDENT BREAKDOWN BY CHARACTERISTIC
(check all that apply)

Nature of Injury	Part of Body Affected
<input type="checkbox"/> Amputation or Enucleation <input type="checkbox"/> Assault <input type="checkbox"/> Burn or Scald <input type="checkbox"/> Contusion, Bruise <input type="checkbox"/> Electric Shock <input type="checkbox"/> Eye, Foreign body in <input type="checkbox"/> Fracture, Broken Bone <input type="checkbox"/> Freezing, Frostbite <input type="checkbox"/> Hearing Loss or Impairment <input type="checkbox"/> Heat Exhaustion, Sunstroke <input type="checkbox"/> Hernia or Rupture <input type="checkbox"/> Infection <input type="checkbox"/> Inhalation Injury-Toxic Substance <input type="checkbox"/> Insect Bites <input type="checkbox"/> Laceration (Cut) <input type="checkbox"/> Multiple Injuries <input type="checkbox"/> Needle Puncture <input type="checkbox"/> Rash, From Plants <input type="checkbox"/> Rash, Not From Plants (Dermatitis) <input type="checkbox"/> Scratches, Abrasions <input type="checkbox"/> Sprain, Strains <input type="checkbox"/> Other	<input type="checkbox"/> No Physical Injury <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes (Including Vision) <input type="checkbox"/> Arm(s) (Above Wrist) <input type="checkbox"/> Hand(s) (Including Wrist) <input type="checkbox"/> Finger(s) and Thumb(s) <input type="checkbox"/> Upper Extremity, Multiple Parts (shoulder, arm, forearm, wrist, or hand) <input type="checkbox"/> Abdomen (Including Internal Organs) <input type="checkbox"/> Back (Including Muscles, Spine) <input type="checkbox"/> Chest (Including Internal Organs) <input type="checkbox"/> Hips (Including Pelvic Organs) <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Trunk, Multiple Parts <input type="checkbox"/> Leg(s) (Above Ankle) <input type="checkbox"/> Foot (Including Ankle) <input type="checkbox"/> Toes <input type="checkbox"/> Lower Extremity, Multiple Parts (from the hip to the toes) <input type="checkbox"/> Multiple Parts of Body, Severe <input type="checkbox"/> Digestive System <input type="checkbox"/> Respiratory System <input type="checkbox"/> Circulatory System <input type="checkbox"/> Skin <input type="checkbox"/> Other
Type of Accidents	Safety Equipment in Use
<input type="checkbox"/> Bodily Reactions (Sprains, Strains, Rupture, Etc.) <input type="checkbox"/> Caught In, Under, Or Between <input type="checkbox"/> Contact With Temperature Extremes (Fire, Cold) <input type="checkbox"/> Disease Exposure <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Falls (All Types) <input type="checkbox"/> Noise Exposure <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Rubbed Or Abraded By Object <input type="checkbox"/> Struck Against Object <input type="checkbox"/> Struck by Flying Object <input type="checkbox"/> Struck by Other Object/Person <input type="checkbox"/> Toxic Materials Exposure <input type="checkbox"/> Vehicle or Equipment Accident <input type="checkbox"/> Other	<input type="checkbox"/> Hard Hat <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Face shield or welder helmet <input type="checkbox"/> Gloves <input type="checkbox"/> Fire Shirt <input type="checkbox"/> Fire Pants <input type="checkbox"/> Safety Shoes <input type="checkbox"/> Fireline Boots <input type="checkbox"/> Ear Protection <input type="checkbox"/> Respirator <input type="checkbox"/> Lanyards & Lifelines <input type="checkbox"/> Fluorescent Vests <input type="checkbox"/> Buoyant Work Vest <input type="checkbox"/> Warning & Control <input type="checkbox"/> Seat Belts <input type="checkbox"/> Shoulder Harness <input type="checkbox"/> Safety Equipment, National Electrical Code (NEC) <input type="checkbox"/> Lab Coat <input type="checkbox"/> Other

When submitting this report, include pictures of incident location, equipment in use, the vehicle used (if applicable), and any third party reports (i.e. Police Report, OSHA Report, etc.).



NORTH CAROLINA WITNESS STATEMENT FORM

Instructions: Before providing the required information below, please note that you will have to certify the truthfulness of this information. You will also be required to acknowledge that you understand that in addition to being disciplined for providing false and/or misleading information, up to and including dismissal, you may also be subjected to additional criminal and/or civil liability. To help you write this statement, please include, if possible, the following information:

Type of Investigation:

Safety Incident Accident Review Near Hit Property Damage

Witness Information

Name:	Title:
Work Address:	Work Phone #:

Incident Information

Date of Incident:	Time of Incident:
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Location of Incident:

Do you have any pictures of the incident?
If yes, please attach them to this submission. Yes No

List the names of anyone present who observed or may have knowledge of the incident.

State what you know about the incident. Indicate who, what, where, and when. Be as specific as possible. If you need more space than what is provided here, create a Word document and attach it to this submission.

I hereby certify that the information I have provided is true and accurate. I acknowledge that any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Witness Name:	Witness Title:
Signature:	Date of Statement: / /