

Report on this form all injuries including diseases that arise out of and in the course of employment. Supervisor and injured employee to complete within 24 hours of accident/injury. Do not leave any lines blank. Use N/A (not applicable) if appropriate.

Injured Employee Name (last, first, middle) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Gender:  Male  Female

Home Address \_\_\_\_\_  
Address City State Zip Code

Home Telephone Number \_\_\_\_\_ Birth Date \_\_\_\_\_

Occupation \_\_\_\_\_ Length of experience on job \_\_\_\_\_ Time employee began work \_\_\_\_\_

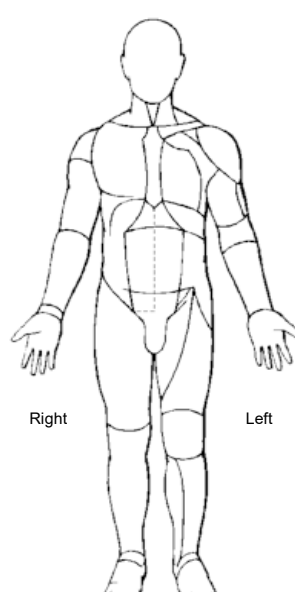
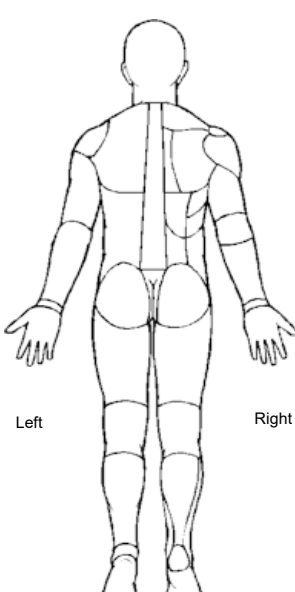
Location, Date and Time of Accident \_\_\_\_\_  
Location Month Day Year Time (include a.m. or p.m.)

Left Work: \_\_\_\_\_ AM PM Returned to Work: \_\_\_\_\_ AM PM Lost Time:  Yes  No

Detailed description of accident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Job/task being performed at time of accident \_\_\_\_\_

Is Personal Protective Equipment (PPE) required for job/task? Yes No If yes, was proper PPE used? Yes No  
If yes, what is required? \_\_\_\_\_

<p><b>CAUSE</b></p> <p><input type="checkbox"/> Slip and fall  <input type="checkbox"/> Struck by equipment  <input type="checkbox"/> Lifting or moving  <input type="checkbox"/> Caught (in, on or between)  <input type="checkbox"/> Needle puncture  <input type="checkbox"/> Object in eye (Right <input type="checkbox"/> Left <input type="checkbox"/>  <input type="checkbox"/> Repetitive/overuse  <input type="checkbox"/> Other: _____</p> <hr/> <p><b>TYPE OF INJURY</b></p> <p><input type="checkbox"/> Scrape/bruise  <input type="checkbox"/> Sprain/strain  <input type="checkbox"/> Puncture wound  <input type="checkbox"/> Cut/laceration  <input type="checkbox"/> Concussion  <input type="checkbox"/> Bite  <input type="checkbox"/> Chemical burn/rash/breathing difficulties  <input type="checkbox"/> Other:  <input type="checkbox"/> No apparent injury:</p>	<p style="text-align: center;"><b>MARK AREAS OF INJURY BELOW:</b></p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p><b>Front</b></p>  <p>Right      Left</p> </div> <div style="text-align: center;"> <p><b>Back</b></p>  <p>Left      Right</p> </div> </div>
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Employee referred to:  Clinic  ER  Hospitalized overnight  Declined medical treatment at this time

Doctor's Name and Address \_\_\_\_\_

Signature of Investigating Security Officer, Title and Date \_\_\_\_\_

Signature of Administrative Supervisor, Title and Date \_\_\_\_\_

Signature of Director of Institutional Facilities and Date \_\_\_\_\_

# KCC Incident Report

## Section 1. Employee Identification

Injured Employee Name (please print) \_\_\_\_\_

Date of Accident \_\_\_\_\_

## Section 2. Injured Employee's Statement

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(Employee's Signature)

## Section 3. Witness Statement

Name of Witness (please print) \_\_\_\_\_

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(Witness' Signature)

## Section 4. Corrective Measures to be completed by Supervisor

Measures implemented to prevent a recurrence of the accident

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Completed by \_\_\_\_\_ Date \_\_\_\_\_

Corrective Measures Implemented by \_\_\_\_\_

Date Corrective Measures implemented \_\_\_\_\_

Verification of implementation by \_\_\_\_\_