KELLOGG COMMUNITY COLLEGE

450 North Avenue, Battle Creek, MI 49017
Phone: (269) 965-4152

Incident Report
Employer's Report on Medical-Only Injury
Michigan Employees

Policy Number: W71D245802 Hanover/Citizens Insurance
Federal I.D. Number 38-1942332

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? _____

CAUSE

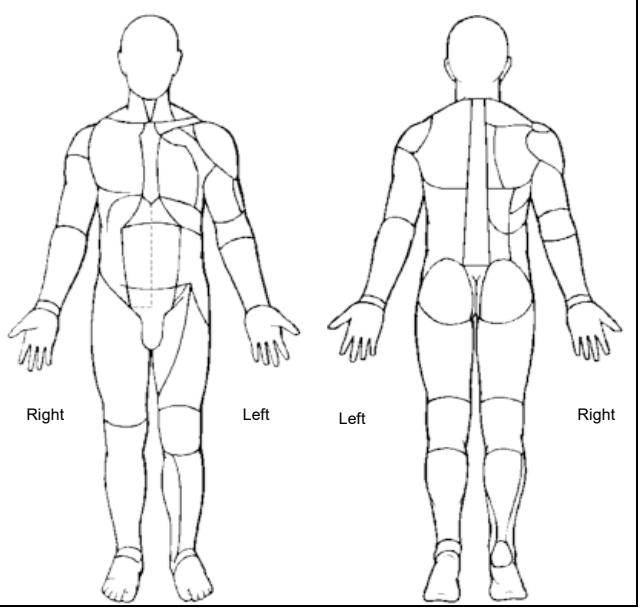
- ☐ Slip and fall
- ☐ Struck by equipment
- ☐ Lifting or moving
- ☐ Caught (in, on or between)
- ☐ Needle puncture
- ☐ Object in eye (Right ☐ Left ☐)
- ☐ Repetitive/overuse
- ☐ Other:

_____

TYPE OF INJURY

- ☐ Scrape/bruise
- ☐ Sprain/strain
- ☐ Puncture wound
- ☐ Cut/laceration
- ☐ Concussion
- ☐ Bite
- ☐ Chemical burn/rash/breathing difficulties
- ☐ Other:
- ☐ No apparent injury:

MARK AREAS OF INJURY BELOW:



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

_____

_____

_____

_____

_____

_____

(**Employee's Signature**)

Section 3. Witness Statement

Name of Witness (please print) _____

_____

_____

_____

_____

_____

_____

(**Witness' Signature**)

Section 4. Corrective Measures to be completed by Supervisor

Measures implemented to prevent a recurrence of the accident

_____

_____

_____

Completed by _____ Date _____

Corrective Measures Implemented by _____

Date Corrective Measures implemented _____

Verification of implementation by _____