

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 _____

Home Telephone Number _____

Birth Date _____

Occupation _____ Length of experience on job _____ Time employee began work _____

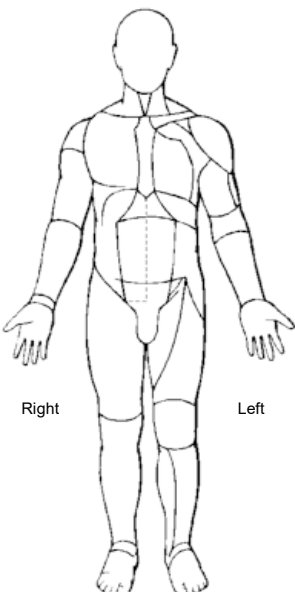
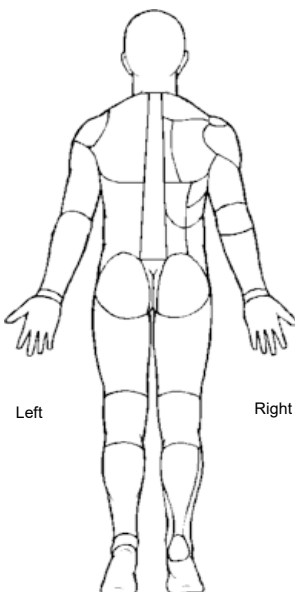
Location, Date and Time of Accident _____

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

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 _____