

Accidental Injury or Occupational Illness Report



INJURED OR ILL PERSON

NAME (Last, First, Middle Initial)		AGE	SEX	CLASSIFICATION	
ADDRESS		DEPARTMENT		TITLE OR STATUS	LENGTH OF EMPLOYMENT
CITY, STATE, ZIP		DATE and TIME of accident or initial diagnosis of occupational illness		Health Insurance YES <input type="checkbox"/> NO <input type="checkbox"/>	

ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS

EXACT LOCATION OF ACCIDENT OR EXPOSURE			NAME OF SUPERVISOR/BUILDING ADMINISTRATOR			
Classroom <input type="checkbox"/>	Grounds <input type="checkbox"/>	Lab <input type="checkbox"/>	Restroom <input type="checkbox"/>	Shop <input type="checkbox"/>	Stairs <input type="checkbox"/>	Other <input type="checkbox"/>
DETAILS OF ACCIDENT OR EXPOSURE TO OCCUPATIONAL ILLNESS (What was the victim doing when injured? How did the accident or exposure occur? Name object or substance which injured victim. Use second sheet if necessary)			ACTION TO PREVENT SIMILAR ACCIDENTS OR EXPOSURE (Indicate if taken or recommended)			
			Witness (Name and Address)			

INJURY OR OCCUPATIONAL ILLNESS

NATURE OF INJURY OR OCCUPATIONAL ILLNESS

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Respiratory conditions due to toxic agent | <input type="checkbox"/> Shock, Fainting |
| <input type="checkbox"/> Bruise, Contusion | <input type="checkbox"/> Exposure, Frostbite | <input type="checkbox"/> Internal Injuries | <input type="checkbox"/> Sprains, Strains |
| <input type="checkbox"/> Burn, Scald | <input type="checkbox"/> Fracture | <input type="checkbox"/> Poisoning, Systemic effects of toxic material | <input type="checkbox"/> Suffocation, Drowning, Strangulation |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Foreign Body | <input type="checkbox"/> Disorders caused by non-toxic materials | <input type="checkbox"/> Rupture, Hernia |
| <input type="checkbox"/> Cuts, Open wounds | <input type="checkbox"/> Heat exhaustion, Sunstroke | <input type="checkbox"/> Disorders due to repeated trauma | <input type="checkbox"/> Other, Specify |
| <input type="checkbox"/> Skin disease disorders | <input type="checkbox"/> Dust diseases of lungs | <input type="checkbox"/> Shock, Electrical | |

PART OF INJURED OR AFFECTED (indicate right or left)

BODY SYSTEM AFFECTED

- | | | | | | | | |
|---------------------------------------|----------------------------------|------------------------------------|----------------------------------|---|--------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Jar | <input type="checkbox"/> Back | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Ankle | <input type="checkbox"/> Circulation | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Skull, Scalp | <input type="checkbox"/> Neck | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee | <input type="checkbox"/> Foot | <input type="checkbox"/> Digestive | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Spine | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Lower Leg | <input type="checkbox"/> Toe | <input type="checkbox"/> Excretory | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Chest | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Finger | <input type="checkbox"/> Other, Specify | | <input type="checkbox"/> Musculoskeletal | |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip | | | <input type="checkbox"/> Multiple Body | |

TREATMENT

ESTIMATE OF SEVERITY <input type="checkbox"/> Minor <input type="checkbox"/> Fatal, Specify date of death <input type="checkbox"/> Serious _____ <input type="checkbox"/> Critical _____	EMERGENCY CARE <input type="checkbox"/> First Aid <input type="checkbox"/> Hospital, Medics, Specify <input type="checkbox"/> Private Physician _____ <input type="checkbox"/> Health Center _____	NAME AND ADDRESS OF PHYSICIAN
NUMBER OF DAYS TIME LOSS	DATES OF TIME LOSS	

THIS REPORT

PREPARED BY: _____ TITLE OR STATUS: _____ DATE: _____

DEPARTMENT OR DIVISION: _____ SUPERVISOR SIGNATURE: _____

OCCUPATIONAL INJURY OCCUPATIONAL ILLNESS RISK MANAGER: _____

CLOVER PARK TECHNICAL COLLEGE

ACCIDENTAL INJURY OR OCCUPATIONAL ILLNESS REPORT

(PREPARE THIS REPORT FOR ANY INJURY, ACCIDENT OR ILLNESS THAT OCCURRED ON CAMPUS)

STUDENT ACCIDENTS

1. All accidents, injuries or occupational illness should be reported to your instructor immediately.
2. A report must be completed for each occurrence.
The report should be sent to your instructor, who will forward it to his/her supervisor, and who then sends it to the Risk Manager.
3. If the accident or injury requires medical attention or emergency assistance, the Risk Manager should be notified immediately at X5603.

NOTE: Clover Park Technical College is not responsible for medical coverage for any student. Each student is encouraged to purchase school medical insurance or carry his/her own medical insurance.

EMPLOYEE ACCIDENTS

1. All accidents, injuries or occupational illness should be reported to your supervisor immediately.
2. A report must be completed for each occurrence.
Upon completion, this report should be sent to your immediate supervisor who will forward it to the Risk Manager.
3. If the accident or injury requires medical attention or emergency assistance, the Risk Manager should be notified immediately at X5603.
4. If an employee requires medical attention, he/she should request a Washington State Labor and Industries Industrial Accident form from the attending physician:
 - a. The employee will complete the necessary information on the employee's section of the form and leave the form with the physician.
 - b. The physician will complete his/her section of the form.
 - c. The Risk Manager will receive claim information from Labor & Industries