

Use this form to **report workplace injury accidents or to report an occupational illness** which has occurred while engaged as a TCC employee during work time. Provide detailed information. Accidents involving students (non TCC student employees), vendors and visitors must be reported to TCC Public Safety at (253) 566-5111. Employees must submit this completed form to their immediate supervisor within 1 day of the date of the incident or upon discovery of an occupational illness.

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| **Person Reporting a workplace injury, accident or report of an occupational illness** |
| Name (please print):       | Phone:       | Email:       |
| Address:       |
| Type: [ ]  Employee [ ]  Student Employee [ ]  Student [ ]  Volunteer [ ]  Visitor [ ]  Other:       |
| **Accident/Incident Details** |
| Date of Accident:       | Time of Accident::       [ ]  AM [ ]  PM |
| Accident Location (building/room/parking lot - be specific):       |
| Condition of Accident Site (wet, dry, icy, dark, other):       |
| **Clearly describe what happened (e.g., cut to left hand index finger while using a hand grinder) and circle the injury location(s) on the figures below. Use the back of form if needed. Be detailed in what lead up to accident, what happened during, and what was done after.** |
|       |  |
| **Medical Treatment/Assistance (check all that apply)** |
|  [ ]  None Required [ ]  First Aid (returned to class/work) [ ]  First Aid (sent home) [ ]  Physician  [ ]  Other Medical/Dental (including clinic/hospital outpatient treatment) [ ]  Assistance provided by public safety [ ] Hospitalized (admitted as inpatient) [ ]  Ambulance: [ ]  Fire Department transport |
| Who provided treatment (list name of provider, clinic/hospital)?       |
| **Person Reporting Accident (if different than person affected)\*** |
| Name:       | Phone:       | Email:       |
| Address:       | Date Reported:       | Time Reported:       [ ]  AM [ ]  PM |
| **Witnesses (attach statement for each)** |
| Name:       | Phone:       | Email:       |
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| **Possible Causes** |
| **Equipment** | **Environment** | **Policies/Procedures** | **Human Factors** |
| [ ]  Defective Tools/Equipment[ ]  Defective Material[ ]  No Guards/Barriers[ ]  Inadequate Guards/Barriers [ ]  Using Equipment Improperly[ ]  Inadequate Maintenance[ ]  Improper Personal Protective Equipment (PPE)[ ]  Lack of PPE[ ]  Other (explain)      \_\_ | [ ]  Inadequate [ ]  Poor Housekeeping Ventilation [ ]  Inclement Weather[ ]  Inadequate [ ]  Slippery/Uneven or Excessive surface Illumination [ ]  Ergonomics Issues[ ]  Air Contaminants [ ]  Sharp Objects[ ]  Chemicals [ ]  Hot Objects[ ]  Noise [ ]  Hot weather conditions[ ]  Fire [ ]  Cold weather cond.[ ]  Explosion [ ]  Animal Action[ ]  Other (explain)      \_\_ | [ ]  Failure to Follow Procedures[ ]  Appropriate Procedures Non-existent[ ]  Inadequate Instructions/ Procedures[ ]  Inadequate Planning/ Preparation[ ]  Inadequate Support/ Assistance[ ]  Other (explain)      \_\_ | [ ]  Inadequate Training [ ]  Verbal Assault[ ]  Inadequate/ Improper [ ]  Physical Assault Protocols/Procedures/ [ ]  Inattention Expectations/PPE [ ]  Loss of Balance[ ]  PPE Not Used [ ]  Rushing[ ]  Improper Lifting [ ]  Phobia/Anxiety[ ]  Failure to Follow [ ]  Horseplay Established Protocols/ [ ]  Other  Procedures (explain)      \_\_ |
| **Suggested Corrective Actions by the Affected Party** |
| [ ]  Provide safety training [ ]  Change/review work procedures [ ]  Submit work order for maintenance/repair[ ]  Undertake hazard assessment [ ]  Provide protocols, procedures and expectations [ ]  Change work area layout/design |
| Suggested corrective action by the affected party:      |
| **Signature(s) – Provide Original Report to Your Supervisor within 1 day of the incident** |
| Signature of Affected Party Date | Signature of Person Reporting Accident Date |

**The following sections to be filled out by Supervisor and the form must immediately be sent to Human Resources in Building 14.**

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| **Supervisor** |
| Possible Cause(s):(Please consider any factor(s) that may have contributed to the accident, including equipment, policies, procedures and/or personnel.) |
| Recommendation(s)/Preventive Measure(s): |
| Name and Title (please print): | Signature: | Date: |
|  |
| Corrective Actions (If any) Target Date: | Corrective Action(s) Completion Date: |
| Name: | Date: | Phone: |
| Approve Investigation and Corrective Actions: 🞎 Yes 🞎 No | Corrective Action(s) Complete: 🞎 Yes 🞎 No |
| Comments: |
| **Human Resources** |
| Date Received: | Time Loss (if any) | Signature: |