

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: | |