

NOTE: Place a check here if this is an occupational (work related) accident.

### ACCIDENT - INCIDENT - INJURY - ILLNESS INVESTIGATION REPORT\*

**Part I** (Complete ALL sections of form. Enter "N/A" if not applicable. Do not leave any blank areas.)  
**EMPLOYER:** Supervisors MUST complete shaded  areas.)

Type of Incident:

Date of this Report:

Unit/Location:

Report No.

1. Name of Diocesan Facility:

2. Mail address (No. and street, City or town, State, and zip code)

3. Location, if different from mail address

### INJURED OR ILL EMPLOYEE/PERSON (COMPLAINANT/VICTIM/SUSPECT)

4. Name			Social Security No.:	
(FIRST)	(MIDDLE)	(LAST)		
5. Home Address				
(No. & Street)		(City/Town)	(State)	(Zip Code)
5a. Phone Number: Residence		Business	6. Age:	7. Sex: M F (Circle One)
8a. Occupation (Enter regular job title, note the specific activity he/she was performing at the time of injury)				
8b. Is this person working at his/her regular job? yes ___ no ___		Sent home? yes ___ no ___		Hospitalized? yes ___ no ___
9. Dept. Number.	9a. Department name (Enter name of department or division in which the injured person is employed, even though they may have been temporarily working in another department at the time of injury)			
10. Place of Accident or Exposure (No. and street, City or town, State and Zip code) (Give exact location)				
11. Was place of accident or exposure on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No			Witness or Fellow Employee:	
Witness or fellow employee Dept./Address/Phone Number:				

### DESCRIPTION OF ACCIDENT/INCIDENT

12. What was person doing? (Be specific. Include tools, machine and materials used.) Name them, and what employee was doing with them)

\_\_\_\_\_

\_\_\_\_\_

13. How accident/incident occurred? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Describe the nature of injury or illness in detail and indicate the part(s) of the body affected. (e.g. amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

15. Name the object or substance which directly injured the employee. (For example, the machine or thing he/she struck against or which struck him/her; the vapor or poison he/she inhaled or swallowed; the chemical or radiation which irritated his/her skin, or in cases of strains, hernias, etc., the thing he/she was lifting, pulling, etc.)  
 \_\_\_\_\_

16a. Date of Accident/Illness/Incident or initial diagnosis of occupational illness. \_\_\_\_\_

16b. Time \_\_\_\_\_ 16c. Date/Time Employee Returned to Work \_\_\_\_\_ 17. Did employee die? (Check one) Yes \_\_\_ No \_\_\_

18. Attending Physician: (Full name, Medical License) \_\_\_\_\_  
 \_\_\_\_\_  
 Identify Medical title MD/DO/D.O.C., etc.) \_\_\_\_\_  
 Office Address \_\_\_\_\_  
 Other Para-Medical: (Identify, Name, Address, etc.) \_\_\_\_\_

19. Transported to Hospital/Clinic? yes \_\_\_\_\_ no \_\_\_\_\_ (If yes, note agency)  
 Hospital/Clinic: (Identify, Address) \_\_\_\_\_  
 \_\_\_\_\_

**Part II**

Identify all damaged equipment or property by name, type, model, etc.	EQUIPMENT OR PROPERTY DAMAGED <u>Ownership</u>	LOST/FOUND/STOLEN <u>Estimate of Damages (labor and parts)</u>
Incident Reported by: _____		Report Prepared by: _____
Address: _____ _____		Phone: _____  Signature, Title _____
Reviewed by Safety Representative _____ (Signature)		
Distribution: _____ _____	Status: { } open      { } closed      Date: _____  NOTE: Determine if this incident/accident should be reported to respective insurance company. [ ] yes      [ ] no      Date Reported _____	

\*This report does not include every loss potential, but relates only to the potential hazards, and conditions examined and described in this report. It does not include violations of any federal, state or local statute, ordinance or regulation since we have made no judgment whether or not such violation exists. NOTE: Part One of this form is meant to meet the recordkeeping requirements of the OSHA Form No. 101, Bureau of Labor Statistics Supplementary Record of Occupational Injuries and Illnesses. Maintain this report in the establishment for a minimum of five (5) years.