NORTH CAROLINA EMPLOYEE INCIDENT REPORT

Instructions: Employee must complete report. If more room is needed, continue in a Word document and attach it to this submission.

Employees are required to complete this form for all incidents and near hits. This form should be completed in its entirety and should be an accurate and truthful account of the accident/incident. Providing false and/or misleading information may result in disciplinary action up to or including dismissal and/or additional criminal and/or civil liability. This form should be completed by the employee only.

Supervisor Review: If an employee is unable to complete this form, the Supervisor must list reason(s) for assisting or completing this report.

My signature below certifies that the information I have provided is true and accurate. I further understand that this information may be used to determine whether the claim will be paid or denied and that I should not complete this form unless there are exceptional circumstances present preventing the employee from completing this form. Check ☐ Not applicable (employee completed form) or sign below if you assisted with the completion of this form.

Supervisor Name: Signature:

Employee Information			Date/Location Information	
Name (Full):			Date of Incident: / /	Time of Day:
Employee ID #:			Date Reported to Supervisor: / /	Time of Day:
Job Title:		☐ Male ☐ Female	Work Address:	
Telephone #:				
Department:			Incident Location (address, Building name, office, cross streets, fire name, woods, facility, room #, etc.):	
Agency/University:				
Supervisor:	Phone #:			
Date Hired:	Time in Current Job:		County:	

Witness Information

Were there any witnesses to the incident? ☐ Yes ☐ No Number of Witnesses (if applicable): _____

If yes, list all known witnesses/phone #'s below, please include additional names on attachment if needed.

Name: Phone #:

Name: Phone #:

Medical Information

Part(s) of the body injured:

Prior to this accident/incident, have you ever been hurt, suffered injury, or received treatment for the body part(s) listed above? ☐ Yes ☐ No

If yes, please provide the date of prior injury, type of injury, names of treating physician or practice group.

Description of Accident/Incident

What was the root cause of the incident? Ask why, and then ask why again. (e.g. Why? I slipped on scrap metal. Why? The work area was not cleaned up. Why? I was rushing to get project done and did not take time to clean up the work area.)

Suggested Corrective Actions

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Employee Name Signature Date / /

NORTH CAROLINA SUPERVISOR INCIDENT INVESTIGATION REPORT

Instructions: Begin investigation within 24 hours and attach the Employee Incident Report and Witness Reports to this report. Forward all reports within 72 hours to the Program Administrator. If more room is needed, continue in a Word document and attach it to this submission.

Agency/University:	**Date of Incident:**
Employee Name:	**Employee Phone #:**
Incident Supervisor:	**Supervisor Phone #:**

Incident Classifications (check all that apply)

☐ Near Hit ☐ Injury ☐ Fatality ☐ Property Damage ☐ Spill ☐ Possible Blood Borne Pathogen exposure

Employee required:

☐ First-Aid Only ☐ Medical treatment and released ☐ Hospitalized ☐ Other:

Employee:

☐ Returned to work no restrictions ☐ Returned to work with restrictions ☐ Did not return to work (Lost Days)

Hazard Types (select one based on origination of injury in this preference order)

☐ Violence or injuries caused by people or animals ☐ Transportation ☐ Fires or Explosions
☐ Slips, Trips, Falls Surface Level ☐ Fall from Elevation ☐ Exposure to harmful substances or environment
☐ Contact with objects or equipment (Struck By, Struck Against, Caught-on, Caught between, Puncture, Cut) ☐ Over-Exertion (lifting)
☐ Bodily Motion (reaching, twisting, running) ☐ Other (List Here):

Names of Witnesses Interviewed:

Incident Information

Describe the specific activity the employee was engaged in and the sequence of events. Include objects or substances that directly injured or made the employee ill. Describe tools, equipment, and PPE in use. Describe property damage. Attach pictures or police reports. Describe the estimated damage to any vehicles or equipment (make, model, ID number, etc.)

Is the activity part of the employee's normal job? ☐ Yes ☐ No	**Prior to beginning activity, did the employee review potential hazards/dangers?** ☐ Yes ☐ No	**Date employee last received training for the activity.** / /

What was the root cause of the incident? Ask why then ask why again (e.g. Why? The employee slipped on scrap metal. Why? The work area was not cleaned up. Why? The employee was rushing to get a project done and did not take time to clean up the work area.)

Action taken or will be taken to prevent reoccurrence (If corrective action will occur in the future, provide estimated completion date.)

I hereby certify that the information I have provided is true and accurate. Any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied. I also acknowledge that I understand that in addition to being disciplined for providing false and/or misleading information up to and including dismissal, I may also be subjected to additional criminal and/or civil liability.

Supervisor's Name:	**Signature**	**Date of Report:** / /
Manager's Name:	**Signature**	**Date Reviewed:** / /

The Supervisor will obtain the Managers' signature and forward signed copies of the Employee Report, Witness Statements, and the Supervisor's report to the Program Administrator. The Program Administrator will send the Employee's and Supervisor's reports to the Manager's supervisor, Local Safety Contact, Safety Committee Chairperson, and Agency Safety Director within two business days. The WCA will receive all reports and all supporting documentation.

Program Administrator Name:	**Signature**	**Date** / /

Date Corrective Actions Completed:

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ACCIDENT BREAKDOWN BY CHARACTERISTIC
(check all that apply)

Nature of Injury

- ☐ Amputation or Enucleation
- ☐ Assault
- ☐ Burn or Scald
- ☐ Contusion, Bruise
- ☐ Electric Shock
- ☐ Eye, Foreign body in
- ☐ Fracture, Broken Bone
- ☐ Freezing, Frostbite
- ☐ Hearing Loss or Impairment
- ☐ Heat Exhaustion, Sunstroke
- ☐ Hernia or Rupture
- ☐ Infection
- ☐ Inhalation Injury-Toxic Substance
- ☐ Insect Bites
- ☐ Laceration (Cut)
- ☐ Multiple Injuries
- ☐ Needle Puncture
- ☐ Rash, From Plants
- ☐ Rash, Not From Plants (Dermatitis)
- ☐ Scratches, Abrasions
- ☐ Sprain, Strains
- ☐ Other

Part of Body Affected

- ☐ No Physical Injury
- ☐ Head
- ☐ Neck
- ☐ Eyes (Including Vision)
- ☐ Arm(s) (Above Wrist)
- ☐ Hand(s) (Including Wrist)
- ☐ Finger(s) and Thumb(s)
- ☐ Upper Extremity, Multiple Parts (shoulder, arm, forearm, wrist, or hand)
- ☐ Abdomen (Including Internal Organs)
- ☐ Back (Including Muscles, Spine)
- ☐ Chest (Including Internal Organs)
- ☐ Hips (Including Pelvic Organs)
- ☐ Shoulder(s)
- ☐ Trunk, Multiple Parts
- ☐ Leg(s) (Above Ankle)
- ☐ Foot (Including Ankle)
- ☐ Toes
- ☐ Lower Extremity, Multiple Parts (from the hip to the toes)
- ☐ Multiple Parts of Body, Severe
- ☐ Digestive System
- ☐ Respiratory System
- ☐ Circulatory System
- ☐ Skin
- ☐ Other

Type of Accidents

- ☐ Bodily Reactions (Sprains, Strains, Rupture, Etc.)
- ☐ Caught In, Under, Or Between
- ☐ Contact With Temperature Extremes (Fire, Cold)
- ☐ Disease Exposure
- ☐ Electrical Shock
- ☐ Falls (All Types)
- ☐ Noise Exposure
- ☐ Repetitive Motion
- ☐ Rubbed Or Abraded By Object
- ☐ Struck Against Object
- ☐ Struck by Flying Object
- ☐ Struck by Other Object/Person
- ☐ Toxic Materials Exposure
- ☐ Vehicle or Equipment Accident
- ☐ Other

Safety Equipment in Use

- ☐ Hard Hat
- ☐ Safety Glasses
- ☐ Goggles
- ☐ Face shield or welder helmet
- ☐ Gloves
- ☐ Fire Shirt
- ☐ Fire Pants
- ☐ Safety Shoes
- ☐ Fireline Boots
- ☐ Ear Protection
- ☐ Respirator
- ☐ Lanyards & Lifelines
- ☐ Fluorescent Vests
- ☐ Buoyant Work Vest
- ☐ Warning & Control
- ☐ Seat Belts
- ☐ Shoulder Harness
- ☐ Safety Equipment, National Electrical Code (NEC)
- ☐ Lab Coat
- ☐ Other

When submitting this report, include pictures of incident location, equipment in use, the vehicle used (if applicable), and any third party reports (i.e. Police Report, OSHA Report, etc.).

NORTH CAROLINA WITNESS STATEMENT FORM

Instructions: Before providing the required information below, please note that you will have to certify the truthfulness of this information. You will also be required to acknowledge that you understand that in addition to being disciplined for providing false and/or misleading information, up to and including dismissal, you may also be subjected to additional criminal and/or civil liability. To help you write this statement, please include, if possible, the following information:

Type of Investigation:

☐ Safety Incident ☐ Accident Review ☐ Near Hit ☐ Property Damage

Witness Information	
Name:	**Title:**
Work Address:	**Work Phone #:**
Incident Information	
Date of Incident:	**Time of Incident:**
Location of Incident:	
Do you have any pictures of the incident? If yes, please attach them to this submission. ☐ Yes ☐ No	
List the names of anyone present who observed or may have knowledge of the incident.	
State what you know about the incident. Indicate who, what, where, and when. Be as specific as possible. If you need more space than what is provided here, create a Word document and attach it to this submission.	

I hereby certify that the information I have provided is true and accurate. I acknowledge that any inaccurate or false statements may result in a delay in process of this claim. I further understand that this information may be used to determine whether the claim will be paid or denied.

Witness Name:	**Witness Title:**
Signature:	**Date of Statement:** / /