



University of Washington Accident/Incident Report

Contact EH&S at 206-543-7388

Person Reporting Incident*		
Last Name:	First Name:	
Phone:	Email:	
Occupation/Position:	Department:	
Date Reported (yyyy-mm-dd):	Time of Reporting:	
Person Involved or Affected*		
Last Name:	First Name:	
Phone:	Email:	
Public		
Incident Details		
Date of Incident (yyyy/mm/dd):	Time of Incident:	
Campus:	Incident Location/Parking Lot:	
Room:	Other:	
Incident Details:		
Classification (Please select level and check an item below)		
<input type="radio"/> Level 1	<input type="radio"/> Level 2	<input type="radio"/> Level 3
<input type="checkbox"/> Near misses <input type="checkbox"/> Incidents with no body injuries <input type="checkbox"/> Injuries requiring first aid <input type="checkbox"/> Injuries requiring medical treatment <input type="checkbox"/> Injuries involving lost work days	<input type="checkbox"/> Injuries requiring restricted work or job transfer <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Property damage	<input type="checkbox"/> Workplace Violence <input type="checkbox"/> Fire and Explosion <input type="checkbox"/> For EH&S/Risk Management use only. WC cases <input type="checkbox"/> Death <input type="checkbox"/> In-patient hospitalization of the Injured Party
Type of Incident		
Nature of Injury	Body Parts Affected	What caused the harm
<input type="checkbox"/> Open Wound : Laceration, Puncture, Scratch <input type="checkbox"/> Contusion/Abrasion/ Hematoma <input type="checkbox"/> Burns <input type="checkbox"/> Sprains/Strains/Twist <input type="checkbox"/> Fracture/Dislocation <input type="checkbox"/> Pain/Inflammation/ Edema <input type="checkbox"/> Electric Shock <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart/Circulatory Diseases <input type="checkbox"/> Needlestick/Sharps <input type="checkbox"/> Exposure to Potential Infectious Material <input type="checkbox"/> Splash <input type="checkbox"/> Poisoning by Substance	<input type="checkbox"/> Head <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Chest/Shoulders <input type="checkbox"/> Torso/Side <input type="checkbox"/> Back <input type="checkbox"/> Abdomen <input type="checkbox"/> Buttocks <input type="checkbox"/> Elbows	<input type="checkbox"/> Bites/Scratches/Kicks <input type="checkbox"/> Struck by Object <input type="checkbox"/> Contact with Objects <input type="checkbox"/> Overexertion <input type="checkbox"/> Fall from Elevation <input type="checkbox"/> Slip or Trip <input type="checkbox"/> Repetitive Motion Injury <input type="checkbox"/> Bio-hazardous Materials/Infectious Diseases <input type="checkbox"/> Needles/Sharps <input type="checkbox"/> Noise <input type="checkbox"/> Fire
<input type="checkbox"/> Respiratory Conditions <input type="checkbox"/> Mental/Emotional Distress <input type="checkbox"/> Allergy/Sensitivity Reaction <input type="checkbox"/> Chronic Irreversible Disease <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Skin Disorders <input type="checkbox"/> Punctured Ear Drum <input type="checkbox"/> Tuberculosis Infection <input type="checkbox"/> Non-personal Damage <input type="checkbox"/> None <input type="checkbox"/> Other	<input type="checkbox"/> Arms <input type="checkbox"/> Fingers <input type="checkbox"/> Hands/Wrists <input type="checkbox"/> Hip/Pelvis <input type="checkbox"/> Legs <input type="checkbox"/> Knees <input type="checkbox"/> Feet/Ankles/Toes <input type="checkbox"/> Groin <input type="checkbox"/> Body Systems <input type="checkbox"/> None <input type="checkbox"/> Other	<input type="checkbox"/> Electricity <input type="checkbox"/> Chemicals <input type="checkbox"/> Machinery <input type="checkbox"/> Tools/Instruments <input type="checkbox"/> Structures/Surfaces <input type="checkbox"/> Violence: Patient, Staff, Visitors <input type="checkbox"/> Radiation <input type="checkbox"/> Motor Vehicles <input type="checkbox"/> Non-human Primates <input type="checkbox"/> Drugs <input type="checkbox"/> None <input type="checkbox"/> Other

*EH&S has hire date, date of birth, employee's gender and hours of employment on file

Possible Causes

Equipment	Environment	Policies/Procedures	Human Factors	
<input type="checkbox"/> Defective Tools/Equipment <input type="checkbox"/> Defective Material <input type="checkbox"/> No Guards/Barriers <input type="checkbox"/> Inadequate Guards/Barriers <input type="checkbox"/> Using Equipment Improperly <input type="checkbox"/> Inadequate Maintenance <input type="checkbox"/> Improper Equipment <input type="checkbox"/> Other	<input type="checkbox"/> Inadequate Ventilation <input type="checkbox"/> Inadequate or Excessive Illumination <input type="checkbox"/> Air Contaminants <input type="checkbox"/> Chemicals <input type="checkbox"/> Noise <input type="checkbox"/> Fire/Exposion <input type="checkbox"/> Animal Action	<input type="checkbox"/> Poor Housekeeping <input type="checkbox"/> Inclement Weather <input type="checkbox"/> Slippery/Uneven surface <input type="checkbox"/> Ergonomics Issues <input type="checkbox"/> Sharp Objects <input type="checkbox"/> Hot Objects <input type="checkbox"/> Frost Bite <input type="checkbox"/> Heat Stress <input type="checkbox"/> Other	<input type="checkbox"/> Failure to Follow Procedures <input type="checkbox"/> Appropriate Procedures Non-existent <input type="checkbox"/> Inadequate Instructions/Procedures <input type="checkbox"/> Inadequate Planning/Preparation <input type="checkbox"/> Inadequate Support/Assistance <input type="checkbox"/> Other	<input type="checkbox"/> Inadequate Training <input type="checkbox"/> Inadequate/Improper PPE <input type="checkbox"/> PPE Not Used <input type="checkbox"/> Improper Lifting <input type="checkbox"/> Failure to Follow Established Protocols/Procedures <input type="checkbox"/> Verbal Assault <input type="checkbox"/> Physical Assault <input type="checkbox"/> Inattention <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Rushing <input type="checkbox"/> Phobia/Anxiety <input type="checkbox"/> Horseplay <input type="checkbox"/> Other

Suggested Corrective Actions By the Affected Party

<input type="checkbox"/> Provide safety training	<input type="checkbox"/> Change/review work procedures
<input type="checkbox"/> Undertake hazard assessment	<input type="checkbox"/> Provide PPE
<input type="checkbox"/> Submit request for maintenance/repair	<input type="checkbox"/> Other
<input type="checkbox"/> Change work area layout/design	

Suggested corrective action by the affected party:

Management Review

Possible Causes:

(Please look at all the factors that may have contributed to the accident. Such factors may include equipment, policies, procedures, and personnel.)

Recommendations/Preventive Measures:

Supervisor or University Representative

Corrective Actions Target Date (mm/dd/yyyy):		Corrective Actions Complete Date (mm/dd/yyyy):	
Name:	Phone Number:	Email:	
Approve Investigation and Corrective Actions: <input type="checkbox"/> Yes <input type="checkbox"/> No		Corrective Actions Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Comments:

Please keep a copy, send copy to supervisor, and send original to EH&S, Box 354400