

# City of Menasha – Employee Injury Report

EMPLOYEE

Employee Name (First, Middle, Last)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employee Home Telephone No. (      )
-------------------------------------	--	---

INJURY INFORMATION

Employee Home Street Address	City	State	Zip Code	Occupation
------------------------------	------	-------	----------	------------

Birth Date	Date of Hire	County and State where accident or exposure occurred
------------	--------------	--

Injury Date Mo / Day / Yr	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	Last Day Worked Mo / Day / Yr	Date Employer Notified Mo / Day / Yr	Shift working at time of incident (ie 7:00 – 4:00)	<input type="checkbox"/> Did you leave work? <input type="checkbox"/> Estimated Date of Return
------------------------------	---	----------------------------------	---	--	---

Location where injury occurred – be as specific as possible.

Were you or do you anticipate being treated by a medical professional for this injury or illness?  Yes  No

Were you hospitalized for this injury or illness?  Yes  No      Did injury result in loss time  Yes  No Days \_\_\_\_\_

Name and address of medical professional and/or Hospital:

### AREA INJURED

1 <input type="checkbox"/> Head 2 <input type="checkbox"/> Eye      L <input type="checkbox"/> R <input type="checkbox"/> 3 <input type="checkbox"/> Back 4 <input type="checkbox"/> Shoulder      L <input type="checkbox"/> R <input type="checkbox"/> 5 <input type="checkbox"/> Arm      L <input type="checkbox"/> R <input type="checkbox"/> 6 <input type="checkbox"/> Elbow      L <input type="checkbox"/> R <input type="checkbox"/> 7 <input type="checkbox"/> Wrist      L <input type="checkbox"/> R <input type="checkbox"/> 8 <input type="checkbox"/> Hand      L <input type="checkbox"/> R <input type="checkbox"/>	9 <input type="checkbox"/> Finger: Specify _____  10 <input type="checkbox"/> Chest 11 <input type="checkbox"/> Abdomen 12 <input type="checkbox"/> Pelvis 13 <input type="checkbox"/> Hip      L <input type="checkbox"/> R <input type="checkbox"/> 14 <input type="checkbox"/> Leg      L <input type="checkbox"/> R <input type="checkbox"/>	15 <input type="checkbox"/> Knee      L <input type="checkbox"/> R <input type="checkbox"/> 16 <input type="checkbox"/> Ankle      L <input type="checkbox"/> R <input type="checkbox"/> 17 <input type="checkbox"/> Foot      L <input type="checkbox"/> R <input type="checkbox"/> 18 <input type="checkbox"/> Toe: Specify _____  19 <input type="checkbox"/> Other _____
--	--	---

### TYPE OF INJURY

1 <input type="checkbox"/> Abrasion 2 <input type="checkbox"/> Amputation 3 <input type="checkbox"/> Bite  4 <input type="checkbox"/> Bruise 5 <input type="checkbox"/> Burn 6 <input type="checkbox"/> Concussion	7 <input type="checkbox"/> Cut / Laceration 8 <input type="checkbox"/> Foreign Body 9 <input type="checkbox"/> Fracture 10 <input type="checkbox"/> Hearing Impaired 11 <input type="checkbox"/> Infection 12 <input type="checkbox"/> Pain	13 <input type="checkbox"/> Puncture 14 <input type="checkbox"/> Rash / Dermatitis 15 <input type="checkbox"/> Respiratory 16 <input type="checkbox"/> Strain / Sprain 17 <input type="checkbox"/> Other _____
--	--	--

**Injury Description:** Describe your activities when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved. (Use additional page if necessary).

What happened to cause this injury or illness? (Describe how the injury occurred. Use additional page if necessary).

Describe your injury or illness. (State the part of body affected and how it was affected. Use additional page if necessary).

Additional Page(s) attached.

Witness(es) – Names of all employees and non-employees who witnessed your injury or illness. (Use additional page if necessary).

SIGNATURES

Employee Signature:	Date Signed		
Supervisor Signature:	Date Signed		
Report Submitted By:	Work Phone Number:	Position:	Date Submitted:

**Form should be completed within 24 hours of the incident**

**City of Menasha - SUPERVISOR REVIEW OF INJURY OR ILLNESS**

Employee Name (First, Middle, Last)	Injury Date Mo / Day / Yr
-------------------------------------	------------------------------

*This form is to be completed by the employee's supervisor. Please provide information that will supplement the employee's report, noting circumstances which may have contributed to the injury or illness, such as weather conditions, use of protective safety equipment, etc. Be thoughtful and thorough, seeking to identify operations, procedures, use of equipment or modification that could help reduce future incidents.*

**UNSAFE ACT / CONDITION:**

- |  |   |
|--|---|
| <input type="checkbox"/> Housekeeping<br><input type="checkbox"/> Work Practices<br><input type="checkbox"/> Safeguarding devices<br><input type="checkbox"/> Physical and environmental stresses<br><input type="checkbox"/> Facility / design<br><br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Materials / tools<br><input type="checkbox"/> Hazards not recognized<br><input type="checkbox"/> Protective equipment<br><input type="checkbox"/> Exceeding limits (speeds, strengths, etc.) |
|--|---|

**CONTRIBUTING FACTORS:**

- |  |  |
|--|--|
| <input type="checkbox"/> Equipment failure<br><input type="checkbox"/> Used wrong equipment<br><input type="checkbox"/> Housekeeping / Maintenance<br><input type="checkbox"/> Procedure Factors<br><input type="checkbox"/> Improper Body Mechanics (ie: Improper Lifting, carrying)<br><input type="checkbox"/> Slippery or defective floor / work surface<br><input type="checkbox"/> Knowledge / skills lacking<br><input type="checkbox"/> Substance abuse<br><br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Repetitive Motion / Ergonomic<br><input type="checkbox"/> Work Station / Ergonomic<br><input type="checkbox"/> Failure to use protective equipment / devices<br><input type="checkbox"/> Safety Policy / Rule Violation<br><input type="checkbox"/> Unsafe Act<br><input type="checkbox"/> Environmental exposure to toxic substance, noise, etc.<br><input type="checkbox"/> Horseplay |
|--|--|

**CORRECTIVE ACTION (Attach additional pages, if necessary):**

Action to be Taken to Prevent Recurrence:	Responsible Party:	Completion Date:
1		
2		
3		

Supervisor Signature:	Date Signed
Department Manager Signature:	Date Signed

Safety Committee Review notes / recommendations:

**Submit forms to Personnel upon completion**