

BARTON COMMUNITY COLLEGE INCIDENT¹/ACCIDENT REPORT FORM

This report is to be completed for every incident/accident. Injured person must complete applicable sections and forward to the appropriate college official within 24 hours of the incident/accident. BCC employees return completed form to the Office of Human Resources. All others return completed form to the Business Office.

| | | | |
|---|--|--|---|
| Injured | Part 1: Personal Identification | | Group |
| | Name (Last, First, Mi) | | <input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor |
| | Home Address (Address, City, St, Zip) | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
| | Home Phone | Work Phone | Date of Birth |
| | If minor, Name of Parent or Guardian | Address (Address, City, St, Zip) | Phone Number |
| | Part 2: Incident/Accident Description | | |
| | Date of Incident/Accident | Location of Incident/Accident (street address, building name, room number) | |
| | Time of Incident/Accident _____ <input type="checkbox"/> AM <input type="checkbox"/> PM | Premises & Location of Incident/Accident | On college premises? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | How did accident occur? | | |
| | What was individual doing when injured? | | |
| | Name substance or object that directly caused injury. | | |
| | Describe in detail the nature and extent of the injury, indicate part of body involved. | | |
| | Admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date Admitted | Treated by emergency room only? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Hospital name and address: | | Name and address of attending physician or clinic: |
| Did an exposure incident ² occur? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain. | | | |
| Signature | | Date | |
| Witness | How did the incident/accident occur? (words of a witness) | | |
| | Signature of Witness | | Date |

(If employee, please turn over to complete the employee and supervisor sections)

¹ An incident is a non-injury accident or event which did not result in immediate medical attention but could result in a future claim.

² An exposure incident occurs when blood comes in contact with mucous membrane or non-intact skin.

BARTON COMMUNITY COLLEGE INCIDENT³/ACCIDENT REPORT FORM Continued.....

This report is to be completed for every incident/accident. Injured person must complete applicable sections and forward to the appropriate college official within 24 hours of the incident/accident. BCC employees return completed form to the Office of Human Resources. All others return completed form to the Business Office.

| Part 3: Employee Section | | Group |
|--------------------------------------|---|---|
| Date of Birth | Social Security Number | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Employee | If applicable, rank on a scale of 1-5 the factors that could be improved to help prevent this incident/accident. With 1 being the factor needing the most improvement. | |
| | Training _____ Communication _____ Policies/Procedures _____ Inspections _____ Other _____ | |
| | If applicable, specifically indicate what actions/measures are needed to improve the areas ranked above: | |
| | If equipment was involved in the incident/accident, was it equipped with guards? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | |
| | If "yes" to the above question, were the guards in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Were they properly adjusted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Were the guards in good condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | In your opinion, does the work procedure need to be changed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> N/A | |
| | Is there a better way of doing the job involved in the incident/accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> N/A If yes, please specify: | |
| | | |
| Supervisor | If applicable, rank on a scale of 1-5 the factors that could be improved to help prevent this incident/accident. With 1 being the factor needing the most improvement. | |
| | Training _____ Communication _____ Policies/Procedures _____ Inspections _____ Other _____ | |
| | If applicable, specifically indicate what actions/measures are needed to improved the areas ranked above: | |
| | If equipment was involved in the incident/accident, was it equipped with guards? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | |
| | If "yes" to the above question, were the guards in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Were they properly adjusted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Were the guards in good condition? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | In your opinion, does the work procedure need to be changed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> N/A | |
| | Is there a better way of doing the job involved in the incident/accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> N/A If yes, please specify: | |
| | What immediate action has been taken to prevent the recurrence of a similar incident/accident? | |
| Signature of Supervisor ⁴ | Date | |

HR/Business Office 4-30-10

³ An incident is a non-injury accident or event which did not result in immediate medical attention but could result in a future claim.

⁴ Signature indicates supervisor has interviewed the injured and witness, and has reviewed the incident/accident site.