

# VILLANOVA UNIVERSITY OCCUPATIONAL ACCIDENT INVESTIGATION REPORT

## INFORMATION ABOUT THE EMPLOYEE:

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
LAST FIRST MIDDLE MONTH DAY YEAR

BANNER ID: \_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_ GENDER: M  F   
MONTH DAY YEAR

ADDRESS: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

HOME PHONE #: \_\_\_\_\_ RACE/ETHNICITY (optional): \_\_\_\_\_

JOB TITLE: \_\_\_\_\_ DEPARTMENT: \_\_\_\_\_

## INFORMATION ABOUT THE HEALTHCARE PROVIDER:

NAME OF THE PHYSICIAN OR HEALTHCARE PROFESSIONAL: \_\_\_\_\_

IF TREATMENT WAS GIVEN AWAY FROM THE WORKSITE, WHEN AND WHERE WAS IT GIVEN? \_\_\_\_\_

BRYN MAWR HOSPITAL  WORKNET  VEMS  OTHER

WAS THE EMPLOYEE SEEN IN AN EMERGENCY ROOM? YES  NO  WAS THE EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? YES  NO

## INJURY/ILLNESS DESCRIPTION

Type of Injury		Nature of Injury			Body Part (specify R or L)		
Fall from elevation	Overexertion	Abrasion	Laceration	Arm	Head		
Fall on same level	Contact w/ electrical	Amputation	Puncture	Back	Internal organ		
Struck against	Extreme temperature	Burn	Rash	Eye	Leg		
Struck by	Slip/trip	Contusion	Sprain/strain	Face	Neck		
Puncture	Contact w/ chemical	Crushed	Repetitive motion	Finger	Torso		
Caught in/under/btn	Motor vehicle	Foreign body	Illness/infection	Foot/feet	Back		
Rubbed/abraded	Other (describe)	Fracture	Other (describe)	Groin	Wrist		
Bodily reaction		Inhalation		Hand	Multiple		

## INFORMATION ABOUT THE CASE:

LOCATION/BUILDING: \_\_\_\_\_ PMA CLAIM #: \_\_\_\_\_

ILLNESS/INJURY DATE: \_\_\_\_\_ TIME EMPLOYEE BEGAN WORK: \_\_\_\_\_ TIME OF EVENT: \_\_\_\_\_ AM/PM  
MONTH DAY YEAR

WHAT WAS THE EMPLOYEE DOING RIGHT BEFORE THE INCIDENT? \_\_\_\_\_

WHAT HAPPENED? \_\_\_\_\_

WHAT WAS THE EQUIPMENT/MATERIALS INVOLVED THAT DIRECTLY HARMED THE EMPLOYEE? \_\_\_\_\_

NAMES OF ANY WITNESSES: \_\_\_\_\_

## INFORMATION REQUIRED:

WAS PUBLIC SAFETY NOTIFIED? YES  NO  PS CONTROL #: \_\_\_\_\_ COULD THE ACCIDENT REOCCUR? YES  NO

WHAT WAS THE ROOT CAUSE OF THE INCIDENT (*SEE BELOW*)? \_\_\_\_\_

CORRECTIVE ACTION REQUIRED: \_\_\_\_\_

WAS THE EMPLOYEE GIVEN A COPY OF THE WORKER'S COMPENSATION EMPLOYEE NOTIFICATION TO SIGN AND RETURN TO HR? YES  NO

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SUPERVISOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## POSSIBLE ROOT CAUSES:

<u>WORK ENVIRONMENT</u>	<u>ENGINEERING</u>	<u>PERSONAL PROTECTIVE EQUIPMENT</u>	<u>TRAINING</u>
Poor housekeeping	Problem not anticipated	(glasses, gloves, lab coats, etc.)	Training not provided
Contamination/Corrosion	Inadequate maintenance	Not used/used incorrectly	Refresher training less than adequate
Noise/Vibration	Physical configuration inadequate	Faulty equipment	Did not attend provided training
Sharp edges	Tool design/selection	Wrong type used	Instructions less than adequate
Poor lighting	Defective equipment/parts	Wrong type specified	
Excessive cold/heat	Manual force req. exceeded ability		<u>EQUIPMENT</u>
Wet/icy surface		<u>MATERIALS HANDLING</u>	Equipment old/worn out
	<u>PROCEDURES</u>	Load too heavy/unstable/shifted	Design less than adequate
<u>HUMAN ENGINEERING</u>	Not used	Awkward size	
Labels/signs inadequate	Insufficient detail	Damaged packaging	<u>COMMUNICATION</u>
Indiv. inattentive to surroundings	Followed incorrectly	Insufficient hand holds	Misunderstood communication
	Incorrect		Untimely

**NOTE:** If the incident involves exposure to human bodily fluids, an additional report must be completed. That report is located at \_\_\_\_\_