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:

WORK ENVIRONMENT		***ENGINEERING***		***PERSONAL PROTECTIVE EQUIPMENT***		***TRAINING***	
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	☐			***EQUIPMENT***	
Wet/icy surface	☐			***MATERIALS HANDLING***		Equipment old/worn out	☐
		PROCEDURES		Load too heavy/unstable/shifted	☐	Design less than adequate	☐
HUMAN ENGINEERING		Not used	☐	Awkward size	☐		
Labels/signs inadequate	☐	Insufficient detail	☐	Damaged packaging	☐	***COMMUNICATION***	
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 _____

Copies to: Human Resources, Office of Environmental Health & Safety, Public Safety, Supervisor, Employee