Incident Report

This form must be completed by the employee and submitted to the employee's direct supervisor.Supervisors to complete and submit in section 7 of the E-form

Employee Information

Employee's Name:	**SCWA ID #:**	**Phone Number:**
Supervisor's Name:		**Employee's Job Title:**
Employee's home address:		**I am:** ☐Right-Handed ☐Left-Handed
Employee's Email:		

Incident Information

Date of Injury: ___/___/_____
Time of Injury: ___:___AM PM

Date Reported: ___/___/____
Time Reported: __:___AM PM

Reported to a supervisor within one shift?:
☐ YES **Reported to:** _____
☐ NO

Weather Conditions:

☐Rain ☐Wind ☐Snow ☐Fog ☐Storm ☐Temperature ☐No notable weather conditions ☐Other:

Temperature (in °F): _____

Address of the Incident Site:
Street/Building _____
City _____ Zip Code _____

☐Outdoors/Yard ☐Pump Station
☐Indoors/Building ☐Residential/Excavation/Service

Description of the Injury/Incident Severity Characteristics

PPE worn at time of incident (*check all that apply*):

☐Hard Hat ☐Gloves ☐Safety Shoes ☐Rubber Boots ☐Glasses ☐Goggles ☐Respirator ☐Vest ☐Hearing Protection ☐Insect Repellent

- ↓ ☐Cut resistant, ☐Chem gloves, ☐Electrical, ☐Nitrile/Latex, ☐Other: _____
- ↓ ☐Dust Mask, ☐N95 (or equal), ☐Half Face, ☐Full Face
- ↓ ☐Ear Plugs, ☐Earmuffs
- ↓ ☐Bug Spray, ☐Permethrin

Body Part Injured: (*check all that apply*):

☐Head ↓ ☐ Left side ☐ Right side	☐Eye ↓ ☐ Left eye ☐ Right eye	☐Face ↓ ☐ Left side ☐ Right side	☐Mouth ↓ ☐ Left side ☐ Right side	☐Neck ↓ ☐ Left side ☐ Right side	☐Shoulder ↓ ☐ Left ☐ Right
☐Arm ↓ ☐ Left ☐ Right	☐Elbow ↓ ☐ Left ☐ Right	☐Forearm ↓ ☐ Left ☐ Right	☐Wrist ↓ ☐ Left ☐ Right	☐Hand ↓ ☐ Left ☐ Right	☐Fingers ↓ ☐ Right ↓ ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Pinky; ☐ Left ↓ ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Pinky
☐Back ↓ ☐ Right ↓ ☐ Upper ☐ Mid ☐ Lower; ☐ Left ↓ ☐ Upper ☐ Mid ☐ Lower	☐Abdomen ↓ ☐ Left ☐ Right	☐Hip ↓ ☐ Left ☐ Right	☐Thigh ↓ ☐ Left ☐ Right	☐Knee ↓ ☐ Left ☐ Right	☐Lower Leg ↓ ☐ Left ☐ Right
☐Ankle ↓ ☐ Left ☐ Right	☐Foot ↓ ☐ Left ☐ Right	☐Toes ↓ ☐ Right ↓ ☐ Big toe ☐ 2nd toe ☐ 3rd toe ☐ 4th toe ☐ Pinky toe; ☐ Left ↓ ☐ Big toe ☐ 2nd toe ☐ 3rd toe ☐ 4th toe ☐ Pinky toe		☐Other: Please explain	

Injury Cause (*check all that apply*):

☐ Body Movement ☐ Burn ☐ Chemical ☐ Chronic ☐ Environmental ☐ Foreign Object ☐ Hearing Loss
☐ Insect Bite ☐ Material Handling ☐ Motor Vehicle ☐ Object Handled ☐ Occupational ☐ Personal Health ☐ Slip/Trip/Fall
☐ Sprain/Strain ☐ Strike Against ☐ Struck By ☐ Trench Collapse ☐ Other: _____

Injury Type (*check all that apply*):

☐ Insect Bite ☐ Bruise/Swelling ☐ Cut/Laceration ☐ Burn ☐ Head Injury ☐ Hearing Loss ☐ Electric Shock ☐ Internal Damage
☐ Poison Ivy ☐ Sprain/Strain ☐ Dislocation ☐ Fracture ☐ Abrasion/Scrape ☐ Occupational ☐ Other: _____

Thoroughly describe what caused the incident to happen:	**Thoroughly describe what factors led to the incident:**

Attachments: Please submit any applicable attachments to the supervisor to submit on the E-form (ex. photos, MV-104, supplemental documents, etc.)

Name(s) of Witness(es): _____

Did you finish your entire shift on the day of the incident? ☐ YES ☐ NO

Have you ever been treated for a similar injury or condition? ☐ YES ☐ NO ***If yes*, Approx. Date: ___/____**

Medical Treatment

Are you currently seeking treatment:
☐ NONE ☐ Plan to receive treatment
☐ Hospital ☐ Walk-In Clinic ☐ Doctor's Office

Doctor's / Facility Name:

Treatment Center Address:

Street _____ City _____Zip Code_____

Required Signature

By submitting this form, the employee agrees that this is an accurate representation of the accident. Please sign with your name and employee ID number below. By submitting this form, the employee who is represented by Local 393, authorizes the employer (SCWA) to release a copy of this form to Local 393. If the employee does not wish to release this information to Local 393, the employee must indicate it on the written form.

Employee's Signature: _____

Date of Submittal: ___/___/____

Employee ID Number: _____