

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: <input type="checkbox"/> Right-Handed <input type="checkbox"/> 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?: <input type="checkbox"/> YES Reported to: _____ <input type="checkbox"/> NO	
	Weather Conditions: <input type="checkbox"/> Rain <input type="checkbox"/> Wind <input type="checkbox"/> Snow <input type="checkbox"/> Fog <input type="checkbox"/> Storm <input type="checkbox"/> Temperature <input type="checkbox"/> No notable weather conditions <input type="checkbox"/> Other: Temperature (in °F): _____					
	Address of the Incident Site: Street/Building _____ <input type="checkbox"/> Outdoors/Yard <input type="checkbox"/> Pump Station City _____ Zip Code _____ <input type="checkbox"/> Indoors/Building <input type="checkbox"/> Residential/Excavation/Service					
	Description of the Injury/Incident Severity Characteristics					
	PPE worn at time of incident (check all that apply):					
	<input type="checkbox"/> Hard Hat <input type="checkbox"/> Gloves <input type="checkbox"/> Safety Shoes <input type="checkbox"/> Rubber Boots <input type="checkbox"/> Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Respirator <input type="checkbox"/> Vest <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Insect Repellent <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Cut resistant <input type="checkbox"/> Chem gloves <input type="checkbox"/> Electrical <input type="checkbox"/> Nitrile/Latex <input type="checkbox"/> Other: _____ </div> <div> <input type="checkbox"/> Dust Mask <input type="checkbox"/> N95 (or equal) <input type="checkbox"/> Half Face <input type="checkbox"/> Full Face </div> <div> <input type="checkbox"/> Ear Plugs <input type="checkbox"/> Earmuffs </div> <div> <input type="checkbox"/> Bug Spray <input type="checkbox"/> Permethrin </div> </div>					
	Body Part Injured: (check all that apply):					
	<input type="checkbox"/> Head ↓ <input type="checkbox"/> Left side <input type="checkbox"/> Right side		<input type="checkbox"/> Eye ↓ <input type="checkbox"/> Left eye <input type="checkbox"/> Right eye		<input type="checkbox"/> Face ↓ <input type="checkbox"/> Left side <input type="checkbox"/> Right side	
	<input type="checkbox"/> Mouth ↓ <input type="checkbox"/> Left side <input type="checkbox"/> Right side		<input type="checkbox"/> Neck ↓ <input type="checkbox"/> Left side <input type="checkbox"/> Right side		<input type="checkbox"/> Shoulder ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right	
	<input type="checkbox"/> Arm ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Elbow ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Forearm ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Wrist ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Hand ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Fingers ↓ <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Right ↓ <input type="checkbox"/> Thumb <input type="checkbox"/> Index <input type="checkbox"/> Middle <input type="checkbox"/> Ring <input type="checkbox"/> Pinky </div> <div> <input type="checkbox"/> Left ↓ <input type="checkbox"/> Thumb <input type="checkbox"/> Index <input type="checkbox"/> Middle <input type="checkbox"/> Ring <input type="checkbox"/> Pinky </div> </div>		
<input type="checkbox"/> Back ↓ <input type="checkbox"/> Right <input type="checkbox"/> Left ↓ <input type="checkbox"/> Upper <input type="checkbox"/> Upper <input type="checkbox"/> Mid <input type="checkbox"/> Mid <input type="checkbox"/> Lower <input type="checkbox"/> Lower		<input type="checkbox"/> Abdomen ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Hip ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Thigh ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Knee ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Lower Leg ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Ankle ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Foot ↓ <input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Toes ↓ <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Right ↓ <input type="checkbox"/> Big toe <input type="checkbox"/> 2nd toe <input type="checkbox"/> 3rd toe <input type="checkbox"/> 4th toe <input type="checkbox"/> Pinky toe </div> <div> <input type="checkbox"/> Left ↓ <input type="checkbox"/> Big toe <input type="checkbox"/> 2nd toe <input type="checkbox"/> 3rd toe <input type="checkbox"/> 4th toe <input type="checkbox"/> Pinky toe </div> </div>		
<input type="checkbox"/> Other: Please explain						

	Injury Cause (<i>check all that apply</i>):	
	<input type="checkbox"/> Body Movement <input type="checkbox"/> Burn <input type="checkbox"/> Chemical <input type="checkbox"/> Chronic <input type="checkbox"/> Environmental <input type="checkbox"/> Foreign Object <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Insect Bite <input type="checkbox"/> Material Handling <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Object Handled <input type="checkbox"/> Occupational <input type="checkbox"/> Personal Health <input type="checkbox"/> Slip/Trip/Fall <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Strike Against <input type="checkbox"/> Struck By <input type="checkbox"/> Trench Collapse <input type="checkbox"/> Other: _____	
	Injury Type (<i>check all that apply</i>):	
	<input type="checkbox"/> Insect Bite <input type="checkbox"/> Bruise/Swelling <input type="checkbox"/> Cut/Laceration <input type="checkbox"/> Burn <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Electric Shock <input type="checkbox"/> Internal Damage <input type="checkbox"/> Poison Ivy <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Abrasion/Scrape <input type="checkbox"/> Occupational <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you ever been treated for a similar injury or condition? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, Approx. Date:</i> ____/____/____		
Medical Treatment	Are you currently seeking treatment: <input type="checkbox"/> NONE <input type="checkbox"/> Plan to receive treatment <input type="checkbox"/> Hospital <input type="checkbox"/> Walk-In Clinic <input type="checkbox"/> 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: _____