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| **TAMUK-logo.gif** | Work Related Incident Report | Office of Employee ServicesPhone 361-593-3705Fax 361-593-3604  |

**Section 1: *To be completed by Employee* Please PRINT or TYPE Date of Hire:**

|  |  |  |
| --- | --- | --- |
| **TIME****& PLACE** | **Date/Time of incident** | **Location: Street, City, Building, Room No. (Be specific)** |
|  |       |       |
| **PREMISES****CONDITION** | **Type of Premises** | **Conditions** | **Reported to** |  |
|  |  | **University** | [ ]  Yes |
|  | [ ]  | Construction Site | [ ]  | Parking Lot | [ ]  | Dry  | [x]  | Uneven Surface | **Police Dept?** |
|  | [ ]  | Hallway | [ ]  | Sidewalk | [ ]  | Icy | [ ]  | Other:       |  |
|  | [ ]  | Lobby/Entrance | [ ]  | Stairway | [ ]  | Snowy |  |       | **UPD Report #** |       |
|  | [ ]  | Office/Classroom | [ ]  | Street | [ ]  | Wet |  |  |  |  |
|  | [ ]  | Other:       |  | [ ]  | **Not Reported** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **INCIDENT****DESCRIPTION** | **Describe What Happened *(Use additional sheet if necessary)*:** |
|  |       |
| **INJURED****PERSON** | **Name** | **Age** | **Phone No.** |
|  |       |       |       |
|  | **Address** | **Employee UIN#:** |
|  |       |       |
| **DESCRIPTION****OF INJURY****&****MEDICAL TREATMENT** | **Injury - *Describe the type, severity, and body part involved*** |
|  |       |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Was Medical Treatment Given?** |  | **Yes** | [x]  | **No** | [ ]  | **Will seek treatment later** | [ ]  |  |
|  |  |
|  | **Name of Medical Facility/Doctor** | [ ]  | **Transported by Ambulance** |       |
|  |       | [ ]  | **Transported by Other:** |       |
|  |  |
| **PROPERTY****DAMAGE** | **Owner’s Name** | **Address** | **Phone #** |
|  |       |       |       |
|  | **Describe the property and the damage:** |
|  |       |
| **WITNESSES**Give the Full Nameand Number of EachWitness Including Permanent Address |  |  |  |
|  | **Name** | **Address** | **Phone #** |
|  |       |  |  |
|  |       |  |  |
|  |       |  |  |
|  |  |  |  |  |  |  |  |  |
| **Name/Title of the Employee** |  |  |  |  |  |  |
| **completing this Report** |       | **Phone #:** |       |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Department** |       | **Date** |       |

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| **Section 2: To be completed by Supervisor/Superintendent** | ***Note: After speaking to the employee and investigating the incident, the Supervisor / Superintendent is to complete the following:*** |
| **WAS THERE AN UNSAFE ACT OR PRACTICE?** | **Describe What Happened *(Use additional sheet if necessary)*:** |
|       |
| **WAS THERE AN UNSAFE WORKING CONDITION?** | **Describe The Conditions *(Use additional sheet if necessary)*:** |
|       |
| **What actions have you taken to prevent a similar incident?** | **Describe The Precautionary Measures (*Use additional sheet if necessary)*:** |
|       |

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| **Name/Title of the Supervisor / Superintendent** |  |  |  |  |  |
| **completing this Report** |       | **Phone #:** |       |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **Department** |       | **Date** |       |

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| **Section 3: To be completed by Director/Chair** | ***Note: This section must be completed by the Director / Chair of the Department and*** ***forwarded to the EHS and HR offices Click Here for E-Mail*** ***:*** |
| **DOES YOUR DEPARTMENT HAVE AN ESTABLISHED RULE / POLICY RELATED TO THIS INCIDENT?** | **Yes** [ ]  | **No** [ ]  | **N/A** [ ]  | Was the rule/policy violated in this incident? **Yes** [ ]  **No** [ ]  |
| **Within your department what measures have you taken to prevent or minimize the recurrence of a similar incident?**       |
| **FOR OTHER MEASURES TAKEN OR MEASURES THAT ARE NEEDED:** | **Describe The Measures *(Use additional sheet if necessary)*:** |
|       |

|  |  |  |  |  |  |
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| **Name/Title of the Director / Chair** |  |  |  |  |  |
| **completing this Report** |       | **Phone #:** |       |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **Department** |       | **Date** |       |

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| **Section 4: To be completed by EHS Office** | ***Note: This section is to be completed by the Manager of Environmental Health & Safety:*** |
| **Based on EHS analysis, was the incident caused by improper supervision of lack of departmental support (i.e., not providing the necessary tools or equipment or providing other necessary resources)? Yes** [ ]  **No** [ ]  |
| **If YES, answer the following:****Was the Operation / Activity properly planned and supervised? Yes** [ ]  **No** [ ]  **N/A** [ ] **Was a safety policy obtained or prepared prior to the activity? Yes** [ ]  **No** [ ]  **N/A** [ ] **Was the safety policy enforced during the activity? Yes** [ ]  **No** [ ]  **N/A** [ ] **Was the employee properly trained prior to the activity? Yes** [ ]  **No** [ ]  **N/A** [ ] **Did the employee have the proper tools and equipment** **necessary to conduct the activity safely? Yes** [ ]  **No** [ ]  **N/A** [ ]  | **EHS Comments:**        |
| **Name:** |       | **Date:** |       |

**INSTRUCTIONS FOR COMPLETION OF INCIDENT/INJURY/PROPERTY DAMAGE REPORT**

1. REPORT ALL SERIOUS INJURIES AND SAFETY HAZARDS TO CAMPUS POLICE DEPARTMENT ext. 2611 AND SAFETY OFFICE ext. 2646.
2. THE TAMUK EMPLOYEE INVOLVED IN, OBSERVING OR DISCOVERING THE
INCIDENT OR PROPERTY DAMAGE IS RESPONSIBLE FOR COMPLETING THIS REPORT.
3. TO FILL OUT FORM, SIMPLY CLICK ON THE GREY BOX AND BEGIN TYPING. TO SELECT THE NEXT BOX, EITHER CLICK ON IT OR SIMPLY PRESS THE ‘TAB’ KEY.

RELATE ONLY TO THE FACTS ON THIS FORM.

BE OBSERVANT - ATTEMPT TO GET AS MUCH INFORMATION AS POSSIBLE AT THE TIME OF
THE INCIDENT.

1. AFTER SECTION ONE IS COMPLETED, SAVE THIS FILE AND EMAIL THIS TO THE Supervisor / Superintendent OF THE INJURED INDIVIDUAL.
2. AFTER SECTION TWO IS COMPLETED BY THE Supervisor / SuperintendenT, THIS FORM MUST THEN BE FORWARDED TO THE DIRECTOR, CHAIR, OR DEPARTMENT HEAD.
3. DEPARTMENT HEADS ARE RESPONSIBLE FOR SENDING COMPLETED FORM TO THE ehs AND hr OFFICES.
4. DO NOT DISCUSS THE ACCIDENT WITH ANYONE - EXCEPT THE POLICE AUTHORITY AND
THE RISK MANAGEMENT OFFICE.

THE RISK MANAGEMENT OFFICE WILL COORDINATE THE INVESTIGATION AND RESOLUTION
OF CLAIMS. REFER ALL QUESTIONS REGARDING STATUS OF CLAIMS TO THE RISK
MANAGEMENT OFFICE.
5. Supervisors must report any work-related injury or incident to the Safety Office utilizing a completed Incident Report, signed by the department head, within **24 hours** of occurrence.
6. AFTER COMPLETION - FORWARD THIS FORM TO TAMUK Office of Employee Services

OR IF IN NEED OF ANY HELP WITH THIS FORM OR Texas A&M University Kingsville

 OUR PROCEDURES, PLEASE CONTACT OUR OFFICE: MSC 107 College Hall Room 210

 955 N. University Blvd

 Kingsville, Texas 78363

 Phone Number: (361) 593-3705