



Safety and Environmental Management

Incident Reporting Form

Austin Community College
 SEM Department

Instructions:

1. Complete this report within 24 hours of being notified of a work related injury or illness.
2. If you were not present at the time of injury, Interview employee to obtain details.
3. Email the completed and signed report to Safety and Environmental Management Department: See contact information on the last page. Email all listed.

| Employee / Student Information | | | |
|--|----------------------------------|--|-----|
| Employee/Student/Visitor Name | | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor | |
| Home Mailing Address | City | State | Zip |
| Primary Phone Number | Date of Birth | ACCeID | |
| Date of Hire(NA for Students) | Job Title(NA for Students) | Classification (NA for Students) | |
| Department/Group | Instructor/Supervisor/Manager | Instructor/Supervisor/Manager Primary Phone Number | |
| Occurrence Information | | | |
| Type of Incident <input type="checkbox"/> Workplace Injury/Illness <input type="checkbox"/> Near Miss <input type="checkbox"/> Spill/Release <input type="checkbox"/> Fire <input type="checkbox"/> Property Damage <input type="checkbox"/> Business Interruption <input type="checkbox"/> Other Describe: _____ | | | |
| Notes: | | | |
| Date of Incident | Time of Incident | Date Incident Reported to Supervisor | |
| Time Employee Began Work (ex: 8:15) | Location Where Incident Occurred | Witnesses(Names, Addresses, Phone, Numbers) | |
| Name of Supervisor | Supervisor Phone | Type of Injury/Illness | |

| | | | | |
|---|--|--|--|--|
| Describe how the incident, including the actions, occurrences or events that caused the incident: | | | | |
| List all equipment, material, or chemicals employee was using when incident occurred | Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill. | | | | |
| <p>Injury/Illness Factors (Check all that apply and explain below)</p> <p>Was the Injury/Illness due to <input type="checkbox"/> an unsafe act <input type="checkbox"/> unsafe condition or <input type="checkbox"/> both?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Slippery / uneven surface <input type="checkbox"/> Trip Hazard <input type="checkbox"/> Lifting / Material handling <input type="checkbox"/> Repetitive Activities <input type="checkbox"/> Chemical Exposure <input type="checkbox"/> Unaware of hazard <input type="checkbox"/> Tried to save time </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Fatigue influenced action <input type="checkbox"/> No documented procedure <input type="checkbox"/> Less than adequate procedure <input type="checkbox"/> Defective Tool, Equipment or machinery <input type="checkbox"/> Use of wrong tool, equipment or machinery <input type="checkbox"/> Failure to use Personal Protective Equipment <input type="checkbox"/> Failure to follow proper procedures <input type="checkbox"/> Lack of (or improper) Training </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Ignored known hazard <input type="checkbox"/> Tried to avoid effort <input type="checkbox"/> Did not know safe procedure <input type="checkbox"/> Less than adequate design <input type="checkbox"/> Inattention <input type="checkbox"/> Weather Conditions <input type="checkbox"/> Temperature <input type="checkbox"/> Unable to determine </td> </tr> </table> <p>Explanation:</p> | | <input type="checkbox"/> Slippery / uneven surface <input type="checkbox"/> Trip Hazard <input type="checkbox"/> Lifting / Material handling <input type="checkbox"/> Repetitive Activities <input type="checkbox"/> Chemical Exposure <input type="checkbox"/> Unaware of hazard <input type="checkbox"/> Tried to save time | <input type="checkbox"/> Fatigue influenced action <input type="checkbox"/> No documented procedure <input type="checkbox"/> Less than adequate procedure <input type="checkbox"/> Defective Tool, Equipment or machinery <input type="checkbox"/> Use of wrong tool, equipment or machinery <input type="checkbox"/> Failure to use Personal Protective Equipment <input type="checkbox"/> Failure to follow proper procedures <input type="checkbox"/> Lack of (or improper) Training | <input type="checkbox"/> Ignored known hazard <input type="checkbox"/> Tried to avoid effort <input type="checkbox"/> Did not know safe procedure <input type="checkbox"/> Less than adequate design <input type="checkbox"/> Inattention <input type="checkbox"/> Weather Conditions <input type="checkbox"/> Temperature <input type="checkbox"/> Unable to determine |
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| Corrective Actions: | | | | |
| Has employee/student received prior training in how to properly perform the task in which he/she was injured? If Yes, date training was provided _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | | |
| Is training or retraining recommended to correct unsafe behavior? If "yes", type of training scheduled _____ date of scheduled training _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | | |
| Does the affected employee/student have any recommendations to prevent this injury from Recurring? If "yes", explain: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | | |
| Does the Supervisor/Instructor agree with these recommendations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | | |
| List corrective actions taken by Supervisor/Instructor to prevent this injury/illness from recurring. | | | | |

| Treatment Information | | | |
|---|--------------------------------------|---|-----|
| The following questions will provide information that is required in order to meet regulatory requirements and for annual reporting. You may need assistance from the injured employee to complete some of the questions. The following questions are not applicable to Student injuries. | | | |
| Physician / Health care provider name (Last, First, MI) | | | |
| Address | City | State | Zip |
| Did the employee receive restrictions due to the injury/ accident? If yes, please identify what the restrictions were. | | | |
| Did restrictions prevent employee from performing essential functions of their job assignment? Was employee given temporary assignment to another area? | Date restrictions began | Date removed from restrictions | |
| Did employee receive any Doctor Ordered time away from work due to injury / accident? | Date absence due to Dr. orders began | Date employee released by Physician to return to work | |
| Please have employee provide documentation for return to work authorization from Physician (if previously given physicians orders not to return to work). | | | |
| Date submitted to Safety and Environmental Management Office _____ | | | |
| Name of person completing form _____ | | | |
| Signature of person completing form _____ Date _____ | | | |

| Safety and Environmental Management Department Contact Information | | |
|--|------------------|--|
| Please email to all | | |
| SEM / Risk Management | Office Phone | Email |
| Melinda Holland | (512) 223 – 7881 | mcabrer2@austincc.edu |
| Matthew Wenke | (512) 223 – 0279 | matthew.wenke@austincc.edu |
| Raven Landry | (512) 223 - 1021 | raven.landry@austincc.edu |
| Nick Caspers | (512) 223 – 7190 | nicholas.caspers@austincc.edu |
| Michael Garcia | (512) 223 - 7020 | michael.garcia@austincc.edu |
| Chris Beckermann | (832)683-8769 | christopher.beckermann@austincc.edu |