

# Incident/Hazard Report

**INSTRUCTIONS:**

- IF YOU ARE AN EMPLOYEE, complete sections: 1, 2, 4, 5, 6, 7, 8
- IF YOU ARE NOT AN EMPLOYEE, complete sections: 1, 3, 4, 5, 6, 7, 8
- Submit this completed form to the Public Safety Office, Central Campus BE1108 (phone: 206-934-5442)
- If you are reporting a workplace hazard, you may send the copy directly to EHS (phone: 206-934-2904)

**1. LOCATION/DATE OF INCIDENT**

College Location:  Central  Georgetown  SMA  South  WTC  North  Siegel

Date of Occurrence (MM/DD/YYYY): \_\_\_\_\_ Time of Occurrence (HH:MM):  AM  PM

Location of Occurrence (Be Specific): Building: \_\_\_\_\_ Floor/Room: \_\_\_\_\_

Employee/Student Identification Number: \_\_\_\_\_

**2. EMPLOYEE REPORT**

Employee's Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Department: \_\_\_\_\_

Have you reported this occurrence to your supervisor?  Yes  No If "yes," when? \_\_\_\_\_

Have you visited a doctor concerning this injury/illness?  Yes  No

If "yes," whom did you see? \_\_\_\_\_ When did you see the doctor? \_\_\_\_\_

Have you previously sustained this type of injury at work?  Yes  No

If "yes," when? \_\_\_\_\_ Employer at the time of previous injury: \_\_\_\_\_

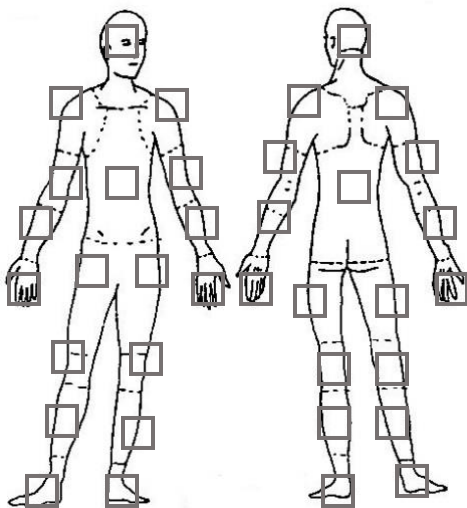
**3. NON-EMPLOYEE REPORT (student/visitor/vendor/contractor)**

Name: \_\_\_\_\_ Program/Affiliation: \_\_\_\_\_

Was there a College employee present at the time of the occurrence?  Yes  No

If "yes," who? \_\_\_\_\_ Department: \_\_\_\_\_

**4. PART OF BODY INJURED (check all that apply):**



**5. NATURE OF THE INJURY (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Abrasion, scrape     | <input type="checkbox"/> Cut/laceration       |
| <input type="checkbox"/> Amputation           | <input type="checkbox"/> Needlestick/puncture |
| <input type="checkbox"/> Back Injury          | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> Broken bone          | <input type="checkbox"/> Illness              |
| <input type="checkbox"/> Bruise               | <input type="checkbox"/> Sprain               |
| <input type="checkbox"/> Burn (heat)          | <input type="checkbox"/> Muscle Sprain        |
| <input type="checkbox"/> Burn (chemical)      | <input type="checkbox"/> Other:               |
| <input type="checkbox"/> Concussion (to head) |   |
| <input type="checkbox"/> Crushing injury      |   |
- I am reporting a(n):
- |   |   |
|---|---|
| <input type="checkbox"/> Injury               | <input type="checkbox"/> Near-miss        |
| <input type="checkbox"/> Work-Related Illness | <input type="checkbox"/> Workplace Hazard |

**6. WITNESSES (if anyone witnessed this occurrence or can corroborate a hazard, please include their name below):**

Name: _____	Job Title: _____
Name: _____	Job Title: _____
Name: _____	Job Title: _____

**7. DESCRIBE THE OCCURRENCE (include what activities were being performed and how the incident occurred):**

If seeking medical treatment at time of occurrence remember to get a doctor's note of release to either full duty, modified/light-duty or no release. If modified/light-duty work is recommended speak with your supervisor to see about accommodations and sign off that they can work within your doctors restrictions. A copy of that note must also be emailed to the Occupational Safety & Health Mgr@Michelle.Valint@seattlecolleges.edu who completes all Workers Compensation claims.

**8. SIGNATURES AND CONTACT INFORMATION**

Signature:	Date:
Completed on behalf of (if you are not the reporting party):	
Describe your relationship to the reporting party (i.e. supervisor, family relation):	
Please provide your contact information below so that we may contact you to discuss this report and any corrective actions taken. You may choose to remain anonymous <b>only</b> if you are reporting a workplace hazard.	
Phone:	Email:

Please complete form and submit to Campus Security on day of incident, security will email a copy to the Occupational Safety&Health Manager

Reviewed By:	Date:
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