

BLINN COLLEGE INCIDENT REPORT

Name and address of person involved in incident: Name Address City State Zip		IDENTIFICATION		SEX	AGE	TIME LOST		
		<input type="checkbox"/> Employee <input type="checkbox"/> Student <input type="checkbox"/> Visitor		<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Yes (If unknown, check "No") <input type="checkbox"/> No (Note: For employees only)		
		INCIDENT DATE		INCIDENT TIME		INCIDENT DAY OF WEEK		
		/ / (mm) (dd) (yy)		<input type="checkbox"/> AM <input type="checkbox"/> PM		<input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		
LOCATION OF INCIDENT			INCIDENT TYPE			NATURE OF INJURY		
Campus: <input type="checkbox"/> Admitting <input type="checkbox"/> Elevator <input type="checkbox"/> Corridors <input type="checkbox"/> Stairs <input type="checkbox"/> Offices # <input type="checkbox"/> Science Lab #	Building: <input type="checkbox"/> Restroom <input type="checkbox"/> Residence Hall <input type="checkbox"/> Cafeteria <input type="checkbox"/> Maint. Dept. <input type="checkbox"/> Security <input type="checkbox"/> Classroom #	<input type="checkbox"/> Stadium-FB <input type="checkbox"/> Stadium-BB <input type="checkbox"/> Track <input type="checkbox"/> Sidewalk <input type="checkbox"/> Parking Lot <input type="checkbox"/> Vehicle # <input type="checkbox"/> Field Trip <input type="checkbox"/> Other:	<input type="checkbox"/> Fall (same level) <input type="checkbox"/> Fall (Elevation) <input type="checkbox"/> Struck Against <input type="checkbox"/> Struck By <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Caught Between <input type="checkbox"/> Bodily Reaction <input type="checkbox"/> Chem. Contact <input type="checkbox"/> Fainted	<input type="checkbox"/> Elec. Contact <input type="checkbox"/> Temperature <input type="checkbox"/> Radiation <input type="checkbox"/> Material Handler <input type="checkbox"/> Friction <input type="checkbox"/> Violence <input type="checkbox"/> Unclassified <input type="checkbox"/> Athletic Event	<input type="checkbox"/> Abrasions <input type="checkbox"/> Amputation <input type="checkbox"/> Broken Bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Cold/Heat <input type="checkbox"/> Cut <input type="checkbox"/> Electrical Shock <input type="checkbox"/> Hearing Loss		<input type="checkbox"/> Open Wound <input type="checkbox"/> Poisoning <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sprain <input type="checkbox"/> Strain <input type="checkbox"/> Multiple Injury <input type="checkbox"/> Other:	
IF AN EMPLOYEE			IF A STUDENT			IF A VISITOR		
Department: Job Title: Date returned to work: First Aid Only: <input type="checkbox"/> Yes <input type="checkbox"/> No			Student Number: Res. Hall Phone: Home Phone #: Resid. Hall Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No			Reason for presence: Home Phone #: Occupation:		
DESCRIPTION OF INCIDENT								
(Including injury and material damage experienced, and corrective action taken, if any, to prevent recurrence):								
Reported by: _____								
Completed by the Risk Manager (or Management's Designee):								
EQUIPMENT INVOLVED			MANUFACTURER			MODEL & SERIAL NUMBER		
INCIDENT INVESTIGATED BY:			TITLE			DATE OF INVESTIGATION		
INCIDENT CAUSES								
(If more than one cause, check predominating one and describe others in lower part of report)								
TRAINING	WORK METHODS	MAINTENANCE	GUARDING	ENVIRONMENTAL	HUMAN ERROR	MISCELLANEOUS		
<input type="checkbox"/> Lack of <input type="checkbox"/> Incorrect <input type="checkbox"/> Ineffective <input type="checkbox"/> Motivation	<input type="checkbox"/> Production demands <input type="checkbox"/> Accepted work proced.	<input type="checkbox"/> Structural defect <input type="checkbox"/> Defective tool <input type="checkbox"/> Machine defect <input type="checkbox"/> Housekeeping	<input type="checkbox"/> Mechanical <input type="checkbox"/> Chemical <input type="checkbox"/> Electrical <input type="checkbox"/> Radiation	<input type="checkbox"/> Noise <input type="checkbox"/> Illumination <input type="checkbox"/> Ventilation <input type="checkbox"/> Exit egress	<input type="checkbox"/> Rules violation <input type="checkbox"/> Haste <input type="checkbox"/> Inattention <input type="checkbox"/> Malicious act	<input type="checkbox"/> Mental state <input type="checkbox"/> Physical state <input type="checkbox"/> Caused by other(s) <input type="checkbox"/> Other:		
INVESTIGATOR COMMENTS:								
RISK MANAGEMENT REVIEW AND FOLLOW-UP								
Risk Manager's Signature:						Review Date:		