



## WORKPLACE SAFETY INCIDENT REPORT FORM

Date and Time:	Reporting Method (e.g. in-person, over phone, email):
Employee Completing the Form:	Department/Division:
Name of the Individual Reporting the Incident:	Contact Information of Reporting Party:
Date of Incident:	Time of Incident:
Street Address of Location Where Incident Occurred:	City/State/Zip:
Location Type (ex: office, clinic, park, hospital, campus):	Area Where Incident Occurred (ex: main lobby, room#)
Safety Incident Type:  <input type="checkbox"/> Threat of Act of Workplace Violence <input type="checkbox"/> Unsafe Condition <input type="checkbox"/> Unsafe Act <input type="checkbox"/> Public Access Issue <input type="checkbox"/> Suggestion <input type="checkbox"/> Near Miss <input type="checkbox"/> Other:	Safety Incident Cause: (Defective equipment, poor ventilation or lighting, exposure to unsafe condition, physical attack, procedures not followed, etc.)
Names of witnesses or others involved:	
Classification of circumstances at the time of the incident: <input type="checkbox"/> Performing usual job duties <input type="checkbox"/> Isolated or working alone <input type="checkbox"/> Working in high crime area <input type="checkbox"/> Lack of equipment <input type="checkbox"/> Working in a poorly lit area <input type="checkbox"/> Other Circumstances	
Type of medical treatment provided:  <input type="checkbox"/> None <input type="checkbox"/> First-Aid <input type="checkbox"/> Fire Paramedic or Ambulance <input type="checkbox"/> Hospital <input type="checkbox"/> Triage with department nurse	

Was environmental sampling done: <input type="checkbox"/> YES <input type="checkbox"/> NO	Which agency conducted the sampling:
Was security or police involved: <input type="checkbox"/> YES <input type="checkbox"/> NO	Security or police agency:
Name or Person(s) who conducted the investigation:	Job Title:
Were findings from the investigation substantiated:	Date of investigation or review:
<p>Detailed incident description, including:</p> <ul style="list-style-type: none"> <li>- All employees and individuals involved before, during and after the incident.</li> <li>- Detailed account of the incident as events occurred, including a specific timeline.</li> <li>- Findings and outcomes from the investigation.</li> </ul>	
<p>What actions have been taken, or are recommended to prevent incident reoccurrence (check all that apply):</p> <input type="checkbox"/> Equipment "Out of Service" for repairs <input type="checkbox"/> Other: (Specify) <input type="checkbox"/> Order new or additional equipment <input type="checkbox"/> Facilities Maintenance Service Requested <input type="checkbox"/> Order new or additional equipment <input type="checkbox"/> New or additional warning signage <input type="checkbox"/> Ergonomic evaluation or job assessment <input type="checkbox"/> Safety procedures to be reviewed or developed	

*(After form is complete, please give to your supervisor and email to DEI@kerncounty.com)*

**For Administrative Tracking Proposes Only**

Reviewer Tracking: To track the movement of the workplace safety incident through the chain of command and record progress taken to mitigate risks to employees, please record your name below if this form is sent to you, in addition to any comments or immediate steps taken (if applicable) and the date sent to the next reviewer.

**Reviewer #1**

Reviewer Name:	Date Received:	Date Sent to Next Reviewer:
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Immediate Action Items Taken and/or Comments:

**Reviewer #2**

Reviewer Name:	Date Received:	Date Sent to Next Reviewer:
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Immediate Action Items Taken and/or Comments:

**Reviewer #3**

Reviewer Name:	Date Received:	Date Sent to Next Reviewer:
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Immediate Action Items Taken and/or Comments:

**Kern County Human Resources**

Reviewer Name:	Date Received:	Date of Committee Meeting (if applicable):
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Action Items Taken and/or Comments: