



# AMHERST COLLEGE

Human Resources  
Box 2204  
79 South Pleasant Street, Suite 200  
(413) 542-2372

<input type="checkbox"/> Recordable	<input type="checkbox"/> Illness
<input type="checkbox"/> Non-Recordable	<input type="checkbox"/> Injury
	<input type="checkbox"/> Hazardous Incident

## INCIDENT REPORT

To be filled out within 24 hours of incident

<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Casual	<input type="checkbox"/> Student
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Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Last Name First Name M.I. Report Date

Dept: \_\_\_\_\_ Sub. Dept: \_\_\_\_\_ Job Title: \_\_\_\_\_  
Date of Hire

INCIDENT DATE: \_\_\_/\_\_\_/\_\_\_ INCIDENT TIME: \_\_\_ A.M./P.M.

Room: \_\_\_\_\_ Building: \_\_\_\_\_ Area: \_\_\_\_\_

BODY PART INJURED: \_\_\_\_\_ INJURY TYPE: \_\_\_\_\_ ACCIDENT TYPE: \_\_\_\_\_

Injury Caused By: \_\_\_\_\_ Equipment/Manufacturer: \_\_\_\_\_ Model #: \_\_\_\_\_ Serial #: \_\_\_\_\_

Chemical/Cleaning Agent or Hazardous Material Involved: \_\_\_\_\_ Was Personal Protective Clothing/Equipment Used? \_\_\_\_\_

If so, what? \_\_\_\_\_ Property Damage: \_\_\_\_\_ Describe Damage: \_\_\_\_\_

INJURY REPORTED TO: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ A.M./P.M.

Task being performed at the time of incident: \_\_\_\_\_  
Employee - please complete the following

Ambulance Requested:  Yes  No First Aid Provided (excluding ambulance personnel): \_\_\_\_\_ By Whom: \_\_\_\_\_

Transported to: \_\_\_\_\_ Incident Cause:  Unsafe Act  Unsafe Condition  Unsafe Equip  No Training  Poor Hskp  Material Handling  Other

Incident Investigated by:  Human Resources  Campus Police  Safety Officer  Supervisor  Other Date of Investigation: \_\_\_/\_\_\_/\_\_\_

Name of Investigator(s): \_\_\_\_\_ Time of Investigation: \_\_\_\_\_ A.M./P.M.

Witnesses: \_\_\_\_\_

Does Incident Warrant Further Investigation?  Yes  No By Whom?  Dept. Head  Human Resources  Safety Officer  Supervisor

Mandatory Field -  
Events and conditions that contributed to the incident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### - Supervisor - please complete the following -

Mandatory Field -  
Supervisor recommendation(s) for corrective action: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

_____ Employee's Signature	_____/_____/_____ Date	_____ Supervisor's Signature	_____/_____/_____ Date
_____ Safety Officer's Signature	_____/_____/_____ Date	_____ Department Head's Signature	_____/_____/_____ Date