SCU EMPLOYEE INCIDENT REPORT FORM

Santa Clara University

Complete within 24 hours and email to ehs@scu.edu and scu-benefits@scu.edu.

IMPORTANT: *Any spills/releases to the environment, injury resulting in death, permanent disfigurement, dismemberment, or hospitalization expected to last more than 24 hours must be reported to EHS* ***immediately*** *(408-551-1606, 408-554-4444 Campus Safety).*

For instructions on other required reporting of workplace injury/ illness, contact HR.

EMPLOYEE TO COMPLETE

PART 1: PERSONAL IDENTIFICATION

Employee Group

☐ Employee
☐ Student employee

For incidents involving students, visitors, and other third-parties, complete the SCU Incident Form 2

Name (*Last, First*)	Department	
Job Title	Work Phone	Home Phone
Employee Start Time	Employee Work Days	
Supervisor Name (*Last, First*)	Title	Work Phone

Work Schedule: ☐ Full-time ☐ Part-time

Bargaining Unit: ☐ Yes ☐ No

PART 2: INCIDENT DESCRIPTION

Date of Incident	Time of Incident	Location of Incident *(Street address or Bldg name, Room#)*

Resulted in employee injury/ illness? ☐ Yes ☐ No

Description of Injury/ Illness *(type of injury/ illness & body part, e.g. sprained rt. ankle, severe cut on left thumb)*:

Resulted in spill or release to environment? ☐ Yes ☐ No

Description of spill or release (*quantity, duration, location, extent of spill/release*):

Incident details--{[illegible]

Witness Name(s)/ Ph. #(s):

- Specific task being performed at time of incident:
- Equipment/ tools involved:
- Materials being handled:
- Unusual condition(s):
- Other relevant details:

Continued on attached sheet (page 3): ☐

Was this an injury caused by an animal (*i.e. bite, scratch*)? ☐ Yes ☐ No

If yes, indicate animal species:

Medical evaluation:
☐ Conducted at SCU contracted medical facility
☐ Conducted at other medical facility:____________
☐ Deemed unnecessary by employee

Date of initial medical evaluation:

Name & Ph# of treating physician:

Important: *For instructions on other required reporting of workplace injury/ illness, contact Human Resources.*

*Employee Signature** *Date*

** Signing of this form does not constitute acceptance of individual fault*

------------- *Give to Supervisor to complete next page* ---------------

Employee Last Name: _____

SUPERVISOR TO COMPLETE

PART 3: ADDITIONAL INCIDENT INFORMATION

Supervisor Comments *(additional information on nature of incident details, etc.)*

Is this a "sharps injury" (*i.e. needlestick, cut, or abrasion*) with an object that may have been contaminated with blood or other potentially infectious material?	☐ Yes ☐ No	**If yes,** Cal/OSHA requires additional reporting- contact EHS at 408-554-5078 or 408-554-4406.

PART 4: POSSIBLE CAUSAL FACTORS

Process/ environment-related: *(Check all that possibly apply)*

- ☐ Housekeeping
- ☐ Work procedure, or lack of
- ☐ Repetitive motion
- ☐ Tool/ equipment condition
- ☐ Tool/ equipment availability
- ☐ Personal protective equipment availability
- ☐ Workstation/ area setup
- ☐ Flooring/ ground
- ☐ Lighting
- ☐ Ventilation
- ☐ Other:

Personnel-related: *(Check all that possibly apply)*

- ☐ Tool/ equipment use or selection
- ☐ Level of support/ assistance
- ☐ Awkward posture(s)
- ☐ Personal protective equipment use
- ☐ Following of procedure/ instruction
- ☐ Level of attention to task
- ☐ Work pacing
- ☐ Other:

Possible Root Cause(S): (*Factors contributing to the workplace condition(s) or action(s) identified above)*

(Check all that possibly apply)

- ☐ Awareness of job hazards
- ☐ Level of training
- ☐ Level of inspection/ maintenance
- ☐ Level of communication
- ☐ Level of resources available
- ☐ Other:

Additional details on possible cause(s):

PART 5: PLANNED FOLLOW-UP EFFORTS

Check all that possibly apply:

- ☐ Conduct ergonomic evaluation (01)
- ☐ Evaluate equipment/ facility condition (02)*
- ☐ Provide appropriate tool/ equipment (03)
- ☐ Provide personal protective equipment (04)
- ☐ Provide initial/ refresher training (05)
- ☐ Post safety signage in area (06)
- ☐ Review inspection and/ or maintenance program (07)
- ☐ Review formal work procedure (08)
- ☐ Assess newly identified hazard(s) (09)
- ☐ Review as job performance issue (10)
- ☐ Other (11):

** For facility-related concerns contact Facilities at 408-554-4742*

Follow-up Action:

For each follow-up effort checked above, indicate its action code (# in parentheses) and describe the planned action. As actions are completed, record completion date, and initial the original copy for local recordkeeping purposes.

Action Code	Description of Planned Action	Date Completed	Supervisor Initial
		Can submit form before completing	*Can submit form before completing*

*Supervisor Signature*** *Date*

*** Signing of this form does not constitute acceptance or assignment of individual fault*

PART 6: IMMEDIATELY EMAIL TO: ehs@scu.edu, scu-benefits@scu.edu

EMPLOYEE INCIDENT DESCRIPTION