Jefferson
Philadelphia University + Thomas Jefferson University
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Injury Report & Investigation Form

To be completed by the employee's supervisor or other responsible administrative official.

Incident Tracking Number:

Complete and submit this form to the HR Office no later than the next working day after the accident. Copy to file.

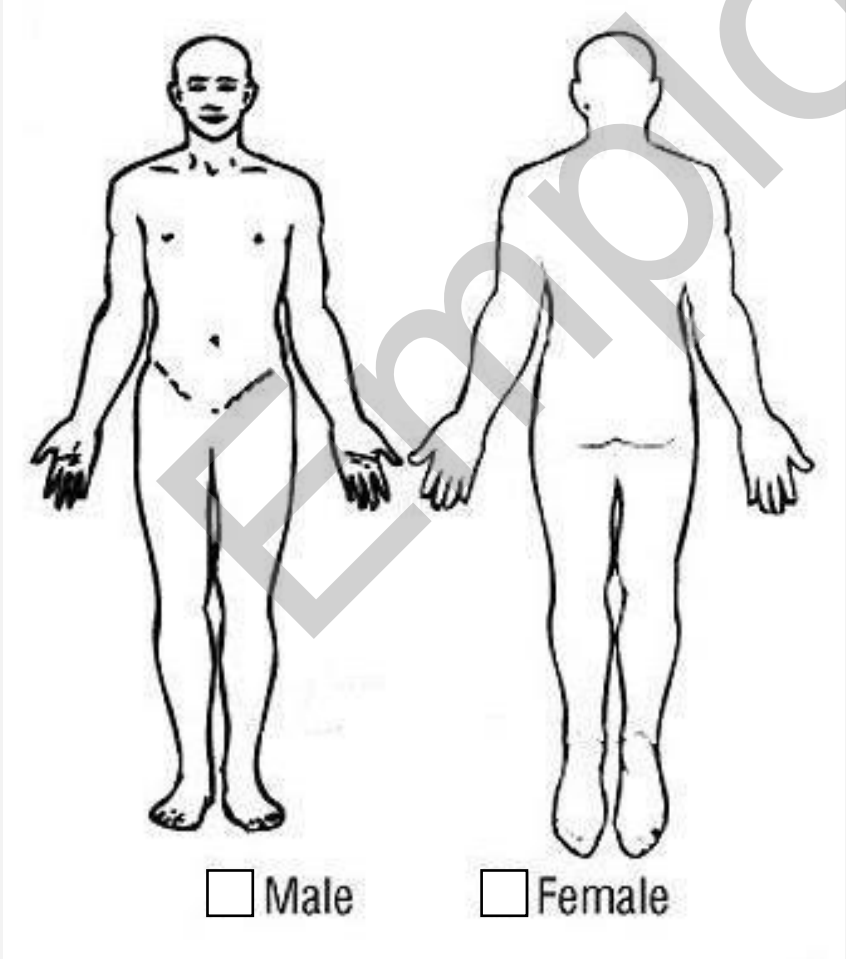
*Only fields relevant to the injury need to be completed

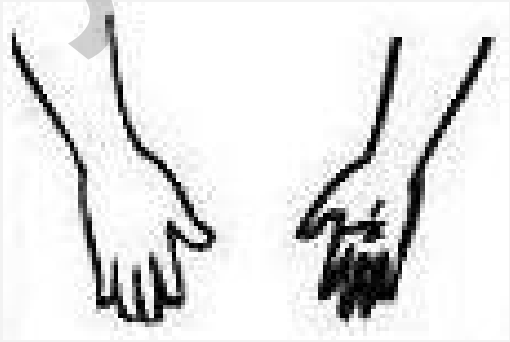
Incident Information						**Subject's Relationship to the University** Mark all that apply ☑							
Day		Date		Time		☐ Employee	☐ Faculty	☐ Full Time
Location						☐ PhilaU Student	☐ Administrator	☐ Part Time
						☐ Visitor / Guest	☐ Support Staff	☐ Casual
Related or Affected Department						☐ Other	☐ Student Worker	
Employer Notified	Date		Time			Supervisor Notified	Date		Time				

Subject's Information													
Name		☐ Male	☐ Female	DOB		ID#							
Residence		Contact				Employer *	☐ PhilaU	☐ Other					
Street		Telephone, Home											
		Telephone, Mobile / Cell											
City		e-mail, Home				Telephone, Work							
State		Zip Code		Other		e-mail, Work							
* If PhilaU employee note Department, Supervisor & Job Title.													

Injury / Illness Information	☐ **N/A**												
Nature of Injury Mark all that apply ☑						**Body Part(s) Injured** Mark all that apply ☑							
☐ Hearing Loss	☐ Abrasion	☐ Contusion	☐ Fracture	☐ Abdomen	☐ Eye	☐ Hip	☐ Shoulder
☐ Poisoning	☐ Amputation	☐ Cut-laceration	☐ Hernia	☐ Ankle	☐ Finger	☐ Knee	☐ Skin
☐ Respiratory Condition	☐ Bruise	☐ Death/Fatality	☐ Infection	☐ Arm, upper	☐ Foot	☐ Leg	☐ Thigh
	☐ Burn, chemical	☐ Dermatitis	☐ Needle stick	☐ Back	☐ Forearm	☐ Lungs	☐ Thumb
☐ Skin Disorder	☐ Burn, thermal	☐ Dislocation	☐ Puncture wound	☐ Chest	☐ Groin	☐ Multiple	☐ Toe
☐ Other Illness	☐ Concussion	☐ Electrical shock	☐ Sprain / Strain	☐ Ear	☐ Hand	☐ Neck	☐ Wrist
☐ Other Injury	☐ Carpal tunnel	☐ Eye injury		☐ Elbow	☐ Head	☐ Other	

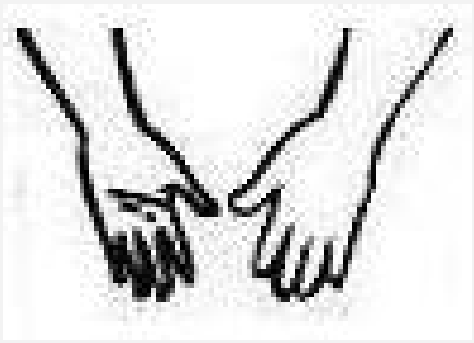
Mark diagram at location of injury





Right hand and forearm

Left hand and forearm



Treatment Mark all that apply ☑						*If Subject is deceased, date of death:	
N/A Not needed		No Medical Care on scene		Treated on Scene by DPS		Clinic / Hospital	
Requested by Subject		Self Care on scene		Treated on Scene by EMS		University Health Center	
Recommended		First Aid provided on scene		Transported by Self		Panel Physician	
Provided		Non-Emergency care		Transported by DPS		Subject's Physician	
Refused by Subject		Emergency Medical care		Transported by EMS		Emergency Department	
If other, describe?							

Returned to Duty		Y		N	Est. Date of Return		Y		N	Restricted Duty		Y		N	Est. Duration	
Notes & Comments																

Incident Information Review ☑

Discuss the accident with the employee involved and with any witnesses. Be sure to question the why, what, where, when, who, how, and any other aspects of the accident.

Subject Interviewed		Y		N		N/A	Date		Incident Information Corroborated		Y		N	Date	
Department Head Contacted		Y		N		N/A	Date		Recommendations Made		Y		N	Date	
Supervisor Interviewed		Y		N		N/A	Date		**Incident Investigation Closed**		Y		N	Date	
Witness(s) Interviewed		Y		N		N/A	Date		**Supplemental Invest Suggested**		Y		N	Date	
Notes & Comments															

Training & Safety Review ☑	Standard Operating Procedures – SOP's							Personal Protective Equipment – PPE							
SOP's for Activity In-place		Y		N		N/A	SOP's Known to Subject		Y		N	SOP's Followed		Y		N
Special Training Needed		Y		N		N/A	Training Provided		Y		N	Training Received		Y		N
Safety Equipment In-place		Y		N		N/A	Safety Equipment Used		Y		N	Safety Equipment Disabled		Y		N
PPE for Activity Needed		Y		N		N/A	PPE Available		Y		N	PPE Used		Y		N
Notes & Comments																

Incident Location & Equipment Condition Review ☑																
Appropriate Work Area		Y		N		N/A	Safe Work Area		Y		N	Safe Working Conditions		Y		N
Appropriate Equipment		Y		N		N/A	Equipment in Good Condition		Y		N	Equipment used as Intended		Y		N
Notes & Comments																

Activity & Experience Review ☑															
Activity within Assigned Duties		Y		N		N/A	Activity within Training & Experience		Y		N		N/A	Yrs. of Service	
Activity Assigned by Supervisor		Y		N		N/A	Activity Assigned by							Yrs. Experience	
Notes & Comments															

Investigators Comments

Recommended Corrective Actions by Department Head Attach additional pages as needed

Person Completing this Report (Name & Title, Contact Telephone Number)		Date Completed:
Health & Safety Committee Investigator (Name & Title, Contact Telephone Number)		
		Date Completed

Forward Report to Jefferson Human Resources