University of Alaska Fairbanks
Facilities Services
Incident Report

SECTION I: EMPLOYEE INFORMATION (completed by employee)

Name____________________________________________________________________ Sex (M/F) _______ Date of Birth _______________________
(Last, First, MI)
Home Address_____________________________________________________________ Home Phone____________________________________
UAF Employee Number_ Date Employed_ Supervisor’s Name_______________________________
Job Title_ (Regular job title, even though doing another job at time of incident)
Department________________________________ Work Phone________________________
(Assigned department, even though working in another department at time of incident)

SECTION II: INCIDENT (completed by employee)

Job title at time of incident________________ Experience in this job________________
Department where incident occurred________________________________ On company premises? Yes ___ No___
Exact location of incident________________________________________________________________

How did the incident occur? Describe events that resulted in incident. What happened? How did it happen? What were you doing? (Be specific)

________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
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________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

Describe injury/illness in detail. Indicate body part(s) affected. (Examples: Twisted left knee with excessive swelling, cut right index finger, etc)

________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

Name the object/substance that directly injured employee. (Examples: lathe, chlorine gas, 50 pound box, etc.)

________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

List all PPE In Use

Name(s) of witness(es)_____________________________________________________________________________________________

Severity of injury (Circle One):       None             First Aid            Medical Treatment
Date of incident_________________ Time____:_______AM ___PM Date employer knew of accident_____________________________

Additional Employee Comments:

________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________

Forward to supervisor for completion of section III (continued on reverse side)
SECTION III: SUPERVISOR’S REPORT OF INCIDENT (completed by employee’s supervisor)

When were you notified of injury/illness? Date_________________________ Time __________ AM____ PM____

Do you agree with the employee’s incident information on side one? ____Yes _____No (provide comments below)

What could have been done to prevent this accident?________________________________________________________

What action have you taken to avoid any reoccurrence?_____________________________________________________

Supervisor’s name_________________________________________ Shop/Department___________________________

Supervisor Signature_____________________________________________ Date_________________________

Forward to Safety Officer for Incident Investigation

SECTION IV: INVESTIGATION (completed by Safety Officer)

Background Information of Incident (provided by employee) validated ___Yes ___No (If no, provide comments_____________________________________

Account of Accident (what happened-sequence of events, extent of damage, type of accident/hazard, agency or source of energy/hazardous material. etc.)

________________________________________________________

Analysis of Accident (How/Why-Direct, indirect, and basic causes) __________________________________________

________________________________________________________

Recommendations to Prevent a Recurrence ______________________________________________________________

________________________________________________________

Safety Officer Name________________________________________________________

Safety Officer Signature__________________________________________________ Date_________________________