UNCLASSIFIED **SAFETY INJURY / INCIDENT REPORT** **FOR OFFICIAL USE ONLY**

TO: SAFETY OFFICER, NAVAL HOSPITAL, PENSACOLA 6000 WEST HIGHWAY 98, PENSACOLA, FL 32512-0003 (CODE 12)

FROM: (Supervisor) _____ ACTIVITY: _____ DATE: _____

OSHA 1904.2(a)(2) states: *"enter each recordable injury and illness on the log as early as practicable but no later than 6 working days..."*

(INJURED PERSON'S INFORMATION)

PAY GRADE	PRIMARY NEC / NOBC	RATING	LAST, FIRST, MI	SSN	DOB	DEPT	PHONE

☐ Military Staff ☐ Federal Civilian Staff ☐ Patient ☐ Red Cross Volunteer ☐ Contract Worker ☐ Visitor

Regular Work Hours: From: _____ ☐ AM ☐ PM To: _____ ☐ AM ☐ PM

Regular Work Schedule: ☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

PRE-EXISTING FACTORS WHICH MAY HAVE CONTRIBUTED TO THE INCIDENT:

DETAILED DESCRIPTION OF THE INCIDENT: ("ALL MOTOR VEHICLE ACCIDENTS REQUIRE A COPY OF THE POLICE REPORT")

Req'd for military only: Marital Status - ☐ Married ☐ Single ☐ Divorced Number of Dependents: _____

Req'd for GS only: Job Title: _____ Classification and Grade: _____

If this was a sharps injury: What type needle or instrument: _____ Size: _____ Manufacturer: _____

Were you wearing PPE? ☐ Yes ☐ No What type? ☐ Gloves ☐ Goggles ☐ Face Shield ☐ Safety Glasses ☐ Seat Belt ☐ Helmet

Was injury incurred? ☐ Yes ☐ No DATE: _____ TIME: _____ LOCATION: _____

Was medical attention required? ☐ Yes ☐ No If Yes, complete Lost Days/Light Duty Sections below (if applicable), and (A) through (D) on reverse side.

Lost workdays (Full Days after date of injury): ☐ Yes ☐ No Date stopped work (MM/DD/YR): _____ Date returned to work (MM/DD/YR): _____

Light Duty: ☐ Yes ☐ No Number of Days:_____ Date light duty started (MM/DD/YR): _____ Date light duty ended (MM/DD/YR): _____

(A) Medical Personnel in Attendance: _____

RATE/RANK LAST NAME FIRST MI TITLE DEPARTMENT PHONE NUMBER

(B) Date/Time of Treatment: _____

(C) Diagnosis/Body Part Injured: _____

Please be specific as to left / right; which finger, foot, eye, part of hand, etc.

(D) Is follow-up visit to doctor required, i.e., removal of stitches: ☐ Yes ☐ No

Witness to the Incident: _____ Phone Number: _____

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NOTE: THIS BOX MUST BE COMPLETED	**WHAT RECOMMENDATIONS WOULD YOU MAKE TO PREVENT SIMILAR INCIDENTS?**

PRIVACY ACT STATEMENT

This information is provided in compliance with the provisions of the Privacy Act of 1974, U.S.C. §552a, which requires that federal agencies inform individuals who are required to furnish personal information about themselves as to certain facts regarding the information requested.

1. **AUTHORITY:** 44 U.S.C. §3101; 5 U.S.C.§301; 10 U.S.C. §972(5); 10 U.S.C. §1201-1221; 10 U.S.C. §2733; 10 U.S.C. §2736-2737; 10 U.S.C. §6148; 31 U.S.C.§82a, 89-92, 95a; 31 U.S.C. §240-243; 31 U.S.C. §71-75, 951-953; 37 U.S.C. §802; 38 U.S.C. §105; 42 U.S.C. §2651-2653; 49 U.S.C. §1901.

THE INFORMATION REQUESTED IS TO BE USED ONLY FOR SAFETY PURPOSES.

_____
Supervisor (Printed/Typed Name)

_____
Department Head (Printed/Typed Name)

_____
Supervisor Signature

_____
Department Head Signature

_____ _____
Phone Number Date

_____ _____
Phone Number Date

COPY TO: Risk Manager, Naval Hospital, Pensacola