Injury/Near Miss Report

Employees are required to report **EVERY** work related injury, illness, or near miss **the day it happens** - No Exceptions No Matter How Minor! - **It is critical that we identify and correct any hazards before they cause serious injury.** This report must be completed by the Injured Employee / Witness / Office as soon as possible. **(Same Day of Event)** **A copy of this form must be given/texted to Chris 801-633-5255 immediately upon completion, no exceptions!**

Work Related Event: ☒ Injury ☐ Illness ☐ Near Miss Date of Event: Time: AM PM

Injured Employee Name: Person Reporting: ☐ Injured Emp. ☐ Witness ☐ Office

Injured Emp. Phone: Person Reporting Name:

Emergency Contact: **RMWP Owner Contacted:** ☐ Call ☐ Text ☐ In Person

Witness Name: Witness Email: Phone:

Location (Address/Lot/GPS/WO#):

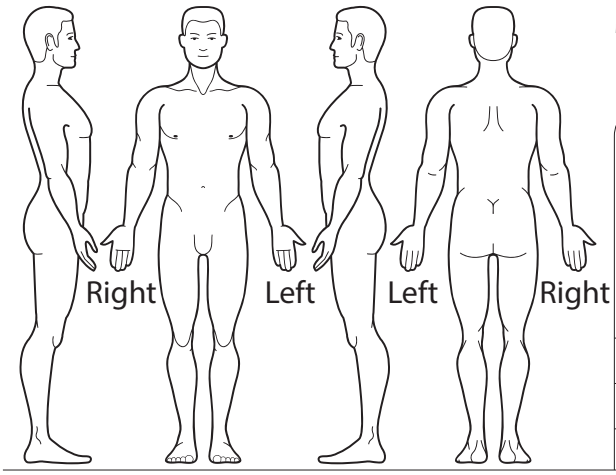
Describe where on site:

Describe Task/Process/Movement done at the time: PPE Used: ☐ Yes ☐ No

Describe in detail (**step by step**) what led up to the event. (Continue on back if needed): JSA: ☐ Yes ☐ No

Injuries/Illnesses/Near Misses are **Preventable**. What things could have been done to prevent this? (**Be Specific**):

Part(s) of Body were injured: (Near Miss what part(s) could have been injured) Draw/Color/Circle



Describe:

Minor First Aid Only (small cut/bruise/etc): ☐ Yes ☐ No

Doctor visit for this Injury/Illness: ☐ Yes ☐ No

Chiropractor visit for this Injury/Illness: ☐ Yes ☐ No

If visit to provider, was it pre-authorized: ☐ Yes ☐ No

Provider Company (if visited):

Provider Name: Date/Time:

Provider Email: Fax: Phone:

Provider Address:

Describe all First Aid / Medical Treatment given: ☐ On Site ☐ RMWP Shop ☐ Provider

Has this Part(s) of Body been injured before? ☐ No ☐ Yes (Describe including when/frequency)

Additional Details about injury / Illness / Near Miss: Pictures of Event location (**Required**): ☐ Yes ☐ Txt Sent

Pictures of injury (**Required**): ☐ Yes ☐ Txt Sent

The Above Report is a true and correct representation of the Injury/Illness/Near Miss to the best of my knowledge I understand that misleading/false information constitutes **fraud** and all incidents will be investigated. I also understand that RMWP has a **return to work program** for accommodating nearly any type of work injury. Please contact Chris 801-633-5255 or Jenn 801-259-2003 with any questions about this form or programs.

Injured Emp. Sign: Date: Witness Sign: Date:

Supervisor Sign: Date: RMWP Sign: Date:

Life Threatening Injuries call **911** or Poison Control **800-222-1222** Immediately