

# WORK SHEET FOR GOVT & CONTRACTOR PRELIMINARY ACCIDENT NOTIFICATION

This work sheet is a field tool to assist the collection of information about an accident and facilitate the completion of a Preliminary Accident Notification. For Member of the Public Recreation Visitor accidents use the Initial Notification of Public Recreation Accident Work Sheet

Project Name: \_\_\_\_\_ Project Office Symbol: \_\_\_\_\_ Date Worksheet Completed: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ Person Completing Worksheet: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Location and Incident Information

Exact Location of Accident: \_\_\_\_\_

Number of Persons Involved: \_\_\_\_\_ Number of Properties Involved: \_\_\_\_\_

## Personnel Classification

Government: Civilian  Military  Government Direct Contractor  Foreign National  Volunteer

Contractor  Member of the Public

## Type of Accident (Mark all that are applicable)

Injury/Illness  Fatality  Motor Vehicle  Property Damage  Fire  Diving

**Personal Data (If more than 2 persons involved provide their personal data on a separate sheet)**

**Person 1** - Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_ Age: \_\_\_\_ Gender: Male  Female

Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_

Job Series/Title: \_\_\_\_\_ Grade: \_\_\_\_ Duty Status: On Duty  Off Duty  TDY  Time Began Work \_\_\_\_\_

Unit and Station Assignment: \_\_\_\_\_ Office Symbol: \_\_\_\_\_ Date Hired: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_ Body Part(s) Affected Primary \_\_\_\_\_ Secondary \_\_\_\_\_

Type of Injury \_\_\_\_\_ Source of Injury \_\_\_\_\_

Severity of Injury: (See definitions on reverse side) Fatality: **Yes/No** Permanent Total Disability: **Yes/No**

Permanent Partial Disability: **Yes/No** Other Serious Injury: **Yes/No**

Estimated Days away from Work: \_\_\_\_\_ Estimated Days Restricted Duty/Job Transfer: \_\_\_\_\_

Primary Language Spoken: \_\_\_\_\_ English Literate: **Yes/No**

Does this person wish to remain anonymous **Yes/No**

What was employee worker doing before the accident occurred? \_\_\_\_\_

Name of Physician/Health Care Professional: \_\_\_\_\_

Medical Treatment Facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

**Person 2** - Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_ Age: \_\_\_\_ Gender: Male  Female

Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_ Job

Series/Title: \_\_\_\_\_ Grade: \_\_\_\_ Duty Status: On Duty  Off Duty  TDY  Time Began Work \_\_\_\_\_

Unit and Station Assignment: \_\_\_\_\_ Office Symbol: \_\_\_\_\_ Date Hired: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_ Body Part(s) Affected Primary \_\_\_\_\_ Secondary \_\_\_\_\_

Type of Injury \_\_\_\_\_ Source of Injury \_\_\_\_\_

Severity of Injury: (See definitions on reverse side) Fatality: **Yes/No** Permanent Total Disability: **Yes/No**

Permanent Partial Disability: **Yes/No** Other Serious Injury: **Yes/No**

Estimated Days away from Work: \_\_\_\_\_ Estimated Days Restricted Duty/Job Transfer: \_\_\_\_\_

Primary Language Spoken: \_\_\_\_\_ English Literate: **Yes/No**

Does this person wish to remain anonymous **Yes/No**

What was employee worker doing before the accident occurred? \_\_\_\_\_

Name of Physician/Health Care Professional: \_\_\_\_\_

Medical Treatment Facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

**Summary of Accident:**(Use additional sheet if needed)

**Remarks:**

**Describe Any Information Released to the Public:**

## Nature of Injury

Amputation  
Abrasion  
Back Strain  
Burn  
Contusion/Bruise  
Concussion  
Dislocation of joint

Drowning  
Fracture  
Hearing Loss  
Hernia  
Laceration/Cut  
Puncture  
Strain

Stroke  
Traumatic Food Poisoning  
Traumatic Heart Condition  
Traumatic Mental Disorder  
Traumatic Respiratory  
(Carbon Monoxide)  
Traumatic Skin Disease

Tuberculosis  
Traumatic Virological/Infective  
Parasitic Disease  
Traumatic Injury Other(list)

## Type of Injury

Struck by/against  
Fell/slipped/tripped  
Caught on/in/between

Punctured/lacerated  
Stung/bit by  
Contact with/by

Exerted  
Exposed  
Inhaled

Ingested  
Absorbed  
Traveling In

## Severity of Injury

Injury

Illness

Fatality

Permanent Disability

## Source of Injury

Environmental  
Condition  
Building or other  
Area  
Walking surface  
Electricity  
Temperature  
Extreme  
Weather

Fire  
Water  
Mechanical  
Equipment  
Guard/Shield  
Video Display  
Terminal  
Heating  
Motor Vehicle/Cycle

Boat  
Bicycle/Other non-  
motorized vehicle  
Noise  
Radiation  
Light  
Ventilation  
Smoke  
Stress

Confined Space  
Carbon Monoxide  
Inanimate Object  
Animal Insect  
Human (Violence)  
Diving Equipment  
Parachute

## Body Parts

Arm or Wrist  
Breast  
Testicle  
Abdomen  
Chest  
Lower Back  
Penis  
Side  
Upper Back  
Waist  
Trunk Other  
Ear  
Eye

Brain  
Cranial Bones  
Teeth  
Jaw  
Throat/Larynx  
Mouth  
Nose  
Tongue  
Head Other External  
Elbow  
Finger  
Thumb  
Toe

Face  
Scalp  
Knee  
Leg  
Hip  
Ankle  
Buttock  
Hand  
Feet  
Collar Bone  
Shoulder Blade  
Rib  
Sternum

Vertebrae  
Trunk Bones other  
Shoulder  
Lung  
Kidney  
Heart  
Liver  
Reproductive Organs  
Stomach  
Intestines  
Trunk/internal