Form 1880 – Report of Occupational Injury / Illness

Compensation Case # _____

(Comp number to be completed by the Person in Charge)

Part 1 – To Be Completed by Employee

Name: _____ Personnel No: _____

Date of occurrence: (mm/dd/yyyy) _____ Time of occurrence: hh:mm AM/PM _____

Date reported: (mm/dd/yyyy) _____ Time reported: hh/mm AM/PM _____

Brief description of incident: (include what happened to cause the injury and/or objects causing the injury – **do not include personal medical information**)
(Add additional sheets as necessary) _____

Crew Size: _____ Crew Type: _____ Vehicle No: _____

Had this type of injury before? _____ **Y or N** If yes, when? (mm/dd/yyyy) _____

Personal Sub Area: _____ Building Symbol: (eg JB) _____ Employment date: _____

Position: _____ Time in position: (# of months) _____

Hours worked prior to injury …… On day of injury: _____ Previous 2 days: _____

Persons present at the time of injury: _____

Part of body injured: _____

Type of injury: _____

Activity or task performed before injury: _____

List any special protective equipment used: _____

Specific Location/Address of Incident (i.e. NE corner of loading dock): _____

Your recommendation for prevention:

Immediate actions you have taken to prevent reoccurrence:

Comments:

(Add additional sheets as necessary)

Part 2 – To Be Completed by the Person in Charge

Vehicle accident? ☐ Yes ☐ No

Action taken to prevent further injury:

Name of treating health care professional:

Name and address of offsite treatment facility:

If fatality, date of fatality:

Time employee started work:

Employee treated by emergency room? Yes☐ No☐ Employee hospitalized overnight? Yes☐ No☐

Did employee lose a full shift after the date of injury? Yes ☐ No ☐ If yes, last day worked:

Crew Module Number (PS only):

If incident involved contact with energized lines or equipment, was it: ☐ Primary ☐ Secondary

_____ _____ _____

Person in Charge Name *Phone* *Building and Mail Stop Code*

_____ _____ _____

Person in Charge Signature *Employee's Signature* *Date*

Submit to Local Safety Committee

Local Safety Committee Case No: _____

Date of Local Safety Committee Review: _____

Part 3 – To Be Completed by the Local Safety Committee (Add additional sheets as necessary)

The local safety committee has reviewed all documentation relative to this accident/incident and submits the following findings and recommendation(s) for corrective action.

Full description of incident:

Factors that contributed to the accident/incident, but on their own would not have caused or prevented the incident:

Safety Rules/Work Methods not adhered to:

Root cause of incident:

***Primary At-Risk Behavior:** ☐ N/A

***Primary At-Risk Barrier:** Haz Rec & Resp ☐ Bus Sys ☐ Facil & Equip ☐ Reward & Recog ☐

Disagree SWP ☐ Personal ☐ Culture ☐ Personal Choice ☐ N/A ☐

COUNTERMEASURES

Recommendations that will prevent reoccurrence (What?):

Method of implementation (How?):

Person responsible for countermeasure?

Date Implementation will be completed? (mm/dd/yyyy)

How will you ensure that countermeasures implemented will remain effective? (checklist, reviews, etc.)

Local Committee Comments:

Joint Safety/Other Committee - Comments/Recommendations:

_____
Management Committee Person

Distribution:

- **Person(s) responsible for corrective action**
- **Employee(s) immediate supervisor/employee in charge**
- **President local union, if bargaining unit**
- **Nuclear Safety, if applicable**
- **Employee**
- **Business unit safety coordinator**
- **Local Supervisor's personnel file (original)**
- **System Council U-4 IBEW, if bargaining unit**
- **Non-bargaining Staff – forward to Corp. Safety JSF/JB**

_____
Local Safety Committee Person
(Union Committee Person if Bargaining Unit)

Date corrective action assigned: _____
(mm/dd/yyyy)

_____
Signature of person responsible for implementation

Date corrective action taken: _____
(mm/dd/yyyy)

_____
Signature of person completing implementation

(rev. 02/09/05)