

NECA/IBEW Injury/Illness Report Form

Date of Injury/Illness:		Job Classification of Injured:	
Department (Check One)	<input type="checkbox"/> Commercial	<input type="checkbox"/> High Voltage	General Task:
	<input type="checkbox"/> Industrial	<input type="checkbox"/> Low Voltage	
	<input type="checkbox"/> Residential	<input type="checkbox"/> Controls	Specific Activity:
	<input type="checkbox"/> High-Tech	<input type="checkbox"/> Service	
	<input type="checkbox"/> Other: _____		
Description of Incident:			
Nature of Injury (Check One)		Injured Body Part (Check all that apply)	
<input type="checkbox"/> Abrasion /Scrape	<input type="checkbox"/> Fracture	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Hand
<input type="checkbox"/> Amputation	<input type="checkbox"/> Frostbite	<input type="checkbox"/> Arm	<input type="checkbox"/> Head
<input type="checkbox"/> Asphyxia	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Back	<input type="checkbox"/> Hips
<input type="checkbox"/> Burn/Chemical	<input type="checkbox"/> Heat Exhaustion/ Stroke	<input type="checkbox"/> Back-Lower	<input type="checkbox"/> Internal Organs
<input type="checkbox"/> Burn/Heat	<input type="checkbox"/> Hernia/Rupture	<input type="checkbox"/> Brain	<input type="checkbox"/> Knee
<input type="checkbox"/> Inhalation	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Chest	<input type="checkbox"/> Leg
<input type="checkbox"/> Concussion	<input type="checkbox"/> Laceration	<input type="checkbox"/> Digestive System	<input type="checkbox"/> Lungs
<input type="checkbox"/> Contusion	<input type="checkbox"/> Multiple	<input type="checkbox"/> Ear/Nose/Throat	<input type="checkbox"/> Multiple Parts
<input type="checkbox"/> Crushing	<input type="checkbox"/> Non-Injury Incident	<input type="checkbox"/> Elbow	<input type="checkbox"/> Neck
<input type="checkbox"/> Dermatitis		<input type="checkbox"/> Eye	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Face	<input type="checkbox"/> Thigh
<input type="checkbox"/> Electric Shock	<input type="checkbox"/> Puncture	<input type="checkbox"/> Finger/Thumb	<input type="checkbox"/> Toe
<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Foot	<input type="checkbox"/> Wrist
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Groin	<input type="checkbox"/> Other: _____
Injury Event Type (Check One)		Extent of Injury/Illness (Check One)	
<input type="checkbox"/> Bodily Reaction	<input type="checkbox"/> Overexertion	<input type="checkbox"/> No Treatment Necessary	
<input type="checkbox"/> Caught in/Under/Between	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> On Site, Self-Administered First Aid	
<input type="checkbox"/> Contact w/Electrical Current	<input type="checkbox"/> Rubbed/Abraded	<input type="checkbox"/> On Site, First Aid Administered by Others	
<input type="checkbox"/> Contact w/Chemical/Radiation	<input type="checkbox"/> Struck Against	<input type="checkbox"/> Off Site Medical Attention – First Aid	
<input type="checkbox"/> Contact w/Temp Extreme	<input type="checkbox"/> Struck By	OSHA Recordable Due to:	
<input type="checkbox"/> Fall from Elevation	<input type="checkbox"/> Tripped and Fell / Lost Balance	<input type="checkbox"/> Prescription Medications	
<input type="checkbox"/> Fall from Same Level	<input type="checkbox"/> Unknown	<input type="checkbox"/> Work Restrictions	
<input type="checkbox"/> Inhalation	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Extent of Injury	
<input type="checkbox"/> Motor Vehicle Accident		<input type="checkbox"/> Type of Medical Treatment	
		<input type="checkbox"/> Lost Time	
		<input type="checkbox"/> Fatality	
Was the Appropriate Safety Equipment Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was it in Use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How Could this Injury/Illness/Incident Been Prevented?			
Gender of Injured Worker		Age of Injured Worker	Months of Service in the Trade
Months of Service with Contractor		Time of Day Accident/Incident occurred	
Day of Week of the Occurrence			

When complete, fax to: 541-736-1449

or

E-Mail to: info@orpacneca.org