

<b>MISHAP REPORT</b>		<i>NOTE: Read the Privacy Act Statement on reverse before completing this form.</i>		1. MISHAP ID NO. (S&H Use Only)	
2. MISHAP DATE (DD-MM-YY)		3. MISHAP TIME (Use Military Clock)		4. MISHAP ORGANIZATION (Organization reporting this mishap)	
5. MISHAP LOCATION (Examples on reverse)					
a. Primary:			b. Secondary:		
6. MISHAP DESCRIPTION (Describe exactly what happened that caused the injury or illness and identify the source(s) of the injury, illness, property damage, and/or vehicle damage and identify the source(s) of the same (i.e., fell down ice covered steps; malfunction of the air conditioning unit led to extreme temperature in office; hit employee with lumber carried by forklift)). Use blank sheets of paper if more room is needed.					
7. IF CONTRACTOR CAUSED MISHAP, PROVIDE CONTRACTOR'S COMPANY NAME:					
8. MOTOR VEHICLE INFORMATION			9. ADDITIONAL VEHICLE INFORMATION		
a. Year	b. Make	c. Type (Car, motorcycle, etc.)	d. Licence Number/State	a. Year	b. Make
e. VIN		f. Estimated Cost of Vehicle Damage		f. Estimated Cost of Vehicle Damage	
10. VALID EQUIPMENT LICENSE/PERMIT <input type="checkbox"/> a. YES <input type="checkbox"/> b. NO		11. SEAT BELT(S) IN USE <input type="checkbox"/> a. YES <input type="checkbox"/> b. NO		12. EQUIPMENT ID NO. (Any identifier such as model or serial number)	
13. DESCRIPTION OF PROPERTY DAMAGED (i.e., 10,000 lbs. forklift, perimeter fence)					
14. EQUIPMENT/PROPERTY/MOTOR VEHICLE DAMAGE DESCRIPTION (i.e., dented left front fender, bent stop sign, broken CRT)					
15. PROVIDE INFORMATION BELOW ABOUT EACH PERSON INVOLVED IN THE MISHAP AND/OR DAMAGE INCIDENT (PLEASE PRINT)					
a. FIRST INDIVIDUAL		b. ADDITIONAL INDIVIDUAL (If needed)		c. ADDITIONAL INDIVIDUAL (If needed)	
Name		Name		Name	
Civilian Employee: <input type="checkbox"/> YES <input type="checkbox"/> NO		Civilian Employee: <input type="checkbox"/> YES <input type="checkbox"/> NO		Civilian Employee: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Employee SSN:		Employee SSN:		Employee SSN:	
Employee Organization		Employee Organization		Employee Organization	
Overtime: <input type="checkbox"/> YES <input type="checkbox"/> NO		Overtime: <input type="checkbox"/> YES <input type="checkbox"/> NO		Overtime: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Military: <input type="checkbox"/> YES <input type="checkbox"/> NO		Military: <input type="checkbox"/> YES <input type="checkbox"/> NO		Military: <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "YES" <input type="checkbox"/> On Duty <input type="checkbox"/> Off Duty		If "YES" <input type="checkbox"/> On Duty <input type="checkbox"/> Off Duty		If "YES" <input type="checkbox"/> On Duty <input type="checkbox"/> Off Duty	
Military Title		Military Title		Military Title	
Date Stopped Work or First Became Aware of Illness		Date Stopped Work or First Became Aware of Illness		Date Stopped Work or First Became Aware of Illness	
*Description of Injury or Illness		*Description of Injury or Illness		*Description of Injury or Illness	
*Description Illness/Injury: Identify the physical characteristics of the injury or illness and the parts of the body affected (i.e., sprained left wrist, cut index finger; fractured right arm; carpal tunnel syndrome affecting left wrist; use "multiple symptoms", to describe symptoms such as abdominal pain, dizziness and headache, all of equal severity). For more than one body part, list each body part affected or use "multiple body parts". Attach any additional information such as medical statements, pictures, other accident reports, etc., that pertain to this mishap.					
<b>SEND THIS FORM TO THE SAFETY AND HEALTH OFFICE IF THE MISHAP HAS NOT ALREADY BEEN REPORTED ELECTRONICALLY VIA SHIRS OR IF THERE ARE ATTACHMENTS</b>					