Injury/Illness Recordability Determination

(See Next Page for Important Notes, including explanations of *italicized* terms)

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| Name of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Report 🞏 or Event 🞏: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Incident #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| 1. Did the incident occur:   While in the *workplace*, or while employee was engaged in a *work-related activity*, or as the results of a *work-related activity?*  🞏 Yes – 2 🞏 No – 5 | 1. Was the event or exposure *instantaneous*?   🞏 Yes – 4A 🞏 No – 3 | | | 1. Does the medical history and evaluation suggest a Cumulative Trauma Disorder (CTD)?   🞏 Yes – 4B 🞏 No – 5 |
| 4A. INJURY – Did the injury results in any of the following 4 injuries?  🞏 Loss of consciousness  🞏 Lost time or restricted work activity  🞏 Job transfer  🞏 Medical treatment\* (beyond First Aid) another  🞏 Yes – Recordable Injury 🞏 No – 5 | 4B. POSSIBLE ILLNESS – Was the abnormal condition or disorder likely to have been caused or aggravated by the work-related incident?  **🞏**  Yes – Continue 🞏 No – 5  Was the *abnormal condition or disorder* diagnosed/recognized by Medical or *trained/experienced person*?  🞏 Yes – Recordable Illness 🞏 No – 5 | | | |
| 1. Explanation of Non-Recordability | | | | |
| 1. Documents Reviewed   🞏 First Report of Injury/Illness  🞏 Incident Investigation Report  🞏 Follow-up Medical Records  🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 1. Summary of Facts | | |
| **Safety and HR have reviewed and discussed the findings and facts of this case, which were used in making the recordability determination.**  Safety\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_  HR/Medical\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_  (\*Required only if Medical located at site)  Concur in determination? 🞏 Yes 🞏 No\*  (\*If No, then contact the Review Team – VP HR, Dir, Safety, Dir., WC)  Date of Team Review:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Recordability Determination:**  **Work-Related?**  🞏 Yes  🞏 No  **Incident Type Recordable?**  🞏 Injury 🞏 Yes  🞏 Illness 🞏 No  🞏 Neither | |

