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 – 5Was the *abnormal condition or disorder* diagnosed/recognized by Medical or *trained/experienced person*?🞏 Yes – Recordable Illness 🞏 No – 5 |
| 1. Explanation of Non-Recordability
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| 1. Documents Reviewed

🞏 First Report of Injury/Illness🞏 Incident Investigation Report🞏 Follow-up Medical Records🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1. Summary of Facts
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| **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 |

