SF SF 2050-P (3-2006) Supersedes (12-00) issue

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Sandia National Laboratories

REPORT OF OCCUPATIONAL INJURY/ILLNESS

(Based on the OSHA definitions and requirements which may or may not be consistent with various state compensation laws)

NOTICE OF INCIDENT

(Pursuant to Chapter 52, NMSA 1978 section 52-1-29)

Instructions: All personnel are required to complete page 1 of this form (e.g., employees at remote sites, contractors). Page 2 pertains only to contracting personnel.

Date received in Medical _____ Case No. _____ Date received in Injury/Illness Reporting _____

Name(Last, First, MI)	Org.	Mail Stop	Sex	Date of Birth	Age	Social Security Number

Date of Incident	Incident Day of Week	Time of Day	Location of Incident (Bldg/Room)	Incident was: Inside/Outside	Hire Date

Job Category (Secretary, electrician, painter, scientist, mechanical tech, etc)	Job experience [(yr(s)mo(s)]	Witness(es)

Type of Injury/Body Part

Briefly describe the activity you were performing and how the incident occurred _____

Employee Signature _____ Work Phone _____ Date _____

INVESTIGATION - MANAGER (Foreman, Inspector, etc.)

A. Was place of Incident or exposure on Sandia's premises Yes ☐ No ☐

B. Was employee sent home due to incident? Yes ☐ No ☐

C. What was the employee doing when incident occurred? Be Specific
Describe the tasks the individual was doing when the injury occurred. Describe the environment including controls where the injury or illness occurred (e.g., employee walking on rocky path, employee spends 6 to 8 hours working on the computer.)

_____

D. Describe what happened. Construct the sequence of events that led up to the incident. Describe the incident. Was the work adequately planned? Was the work adequately supervised? Were hazards identified? Were controls specified and were they used? What PPE was being used?

_____

E. What has been done to correct conditions causing the incident? List any corrective actions taken.

_____

F. How can this incident or injury be mitigated in the future. List any corrective actions that are recommended. By what date?

Manager's Name (print or type) _____

Manager's Signature _____ Org _____ M.S. _____

Date _____ Phone _____

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(Page 2 - Pertains to Contracting Personnel Only)

CONTRACTOR INFORMATION - PLEASE COMPLETE THE FOLLOWING INFORMATION

Contractor Company Name Phone	Name of SNL Supervisor /Inspector Org. M.S. Phone
Workdays Lost	Workdays Restricted

OSHA RECORDABILITY DETERMINATION (To Be filled out by Contracting Company)

Diagnosis

- ☐ Contusion
- ☐ Fracture
- ☐ Laceration
- ☐ Loss of Consciousness
- ☐ Strain/Sprain

Treatment

- ☐ First Aid Only
- ☐ Sutures
- ☐ Prescription Medication
- ☐ OTC Medication
- ☐ Steri-strip/Butterfly
- ☐ Splint (Support)
- ☐ Splint (Immobilize)
- ☐ Other: _____ (please explain)

Disposition

- ☐ Outside Referral
- ☐ Physical Therapy
- ☐ Sent Home
- ☐ Accommodations
- ☐ None of the Above

Examined by physician/NP/PA? Yes ☐ No ☐ Attending medical professional name: _____

INJURY AND ILLNESS REPORTING USE ONLY

DOE Case Recordable Yes ☐ No ☐

Investigative Comments See Attachment ☐ Not Work Related ☐

Safety Reporting Administrator _____ Org _____ M.S. _____ Phone _____ Date _____