SF 2050-P# (12-2000)
Supersedes (7-96) issue

# UCI

Sandia National Laboratories

## REPORT OF OCCUPATIONAL INJURY/ILLNESS

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

*NOTICE OF ACCIDENT*

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

### FOR MEDICAL USE ONLY

Date received in Medical _____ Case No. _____ Date received in Safety _____

| 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: | Service Date |
|---|---|---|---|---|---|
| | | | | | |

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

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

Employee Signature _____ Work Phone _____ Date _____

### CONTRACTOR INFORMATION - PLEASE COMPLETE THE FOLLOWING INFORMATION

| Company Name (Contract Use Only) | Phone | Name of SNL Supervisor /Inspector | Org. | M.S. | Phone |
|---|---|---|---|---|---|
| | | | | | |

| Workdays Lost | Workdays Restricted | Type of Injury |
|---|---|---|
| | | |

### 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 occured? Be Specific
(Was employee using tools, equipment, handling material?, Name them., What was employee doing with them?)

_____

D. How did the incident occur? What was the cause? Describe the event in full detail.
Name any objects or substances involved and tell how they were involved.

_____

E. What has been done to correct conditions causing the incident?

_____

F. What remains to be done to correct such conditions? By what date?

Manager's Name (print or type) _____

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

Date _____ Phone _____

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## MEDICAL INFORMATION

**Diagnosis**

_____

- ☐ Deferred
- ☐ Fracture
- ☐ Loss of Consciousness
- ☐ FB Removal (Medical)
- ☐ FB Removal (First Aid)

**Treatment**

- ☐ First Aid Only
- ☐ Debridement
- ☐ Sutures
- ☐ Prescription Medication
- ☐ OTC Medication
- ☐ Steri-strip/Butterfly
- ☐ Splint (Support)
- ☐ Splint (Immobilize)

**Disposition**

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

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

_____

## SAFETY INFORMATION

DOE Case Recordable Yes ☐ No ☐ Were corrective actions discussed with Manager Yes ☐ No ☐

Investigative Comments/Corrective Action See Attachement ☐ Not Work Related ☐

_____ _____ _____ _____ _____

Safety and Health Representative | Org | M.S. | Phone | Date

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