Print Form

Grice Marine Laboratory Accident Form

Employee Information

Name: _____ Phone Number: _____

Address: _____

Email Address: _____ Date of Birth: _____

Job Title: _____

Supervisor Name and Phone Number: _____

Accident Information

Date: _____ Time: _____ Location (be specific): _____

Description of Injury: _____

Cause of Injury: _____

Medical Treatment Given: _____

Corrective Actions Taken

What corrective actions were taken to resolve this accident?	
What is the likelihood of the accident recurrence?	

Please note: If this was a severe injury, an additional OSHA 301 Form must be filled out