SAFETY TRAINING ACTION PLAN

INJURY TYPE:

☐ WORK-RELATED INJURY ☐ WORK-RELATED ILLNESS ☐ WORK-RELATED ACCIDENT

EMPLOYEE INVOLVED: _____

TITLE: _____ DEPARTMENT: _____

EMAIL ADDRESS: _____ PHONE NO.: _____

SUPERVISOR NAME: _____

DATE INJURY OCCURRED: _____TIME INJURY OCCURRED: _____

DATE SHIFT STARTED: _____ TIME SHIFT STARTED: _____

DATE THE INJURY WAS REPORTED: _____

LOCATION OF INJURY: _____

CAUSE OF INJURY:

_____

_____

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IMPACT TO EMPLOYEE:

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TREATMENT PLAN

A. METHOD OF TRAINING/RETRAINING:

_____

_____

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_____

_____

B. FOLLOW UP DATE: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

SAFETY OPFFICER SIGNATURE: _____ DATE: _____

If there are any questions about this form, please contact incidentreporting@nyecountynv.gov or 775-751-6327.