(Enter all dates in MM/DD/YY format.)

EMPLOYER or COMPANY NAME & ADDRESS:

☐ Marathon Anacortes Refinery ☐ _____ (Contractor)	☐ 10200 West March Point Road, Anacortes WA ☐

EMPLOYEE INFORMATION:

NAME (Last, First, Middle)	EMPLOYEE NUMBER	PHONE NO. (A/C, No.)		
ADDRESS (Include Zip)	CITY	DATE OF BIRTH	MALE ☐	FEMALE ☐
	STATE	HOW LONG AT CURRENT JOB (# Years and/or Months)		
OCCUPATION	SUPERVISORS NAME	CONTACT PHONE NUMBER		

OCCURRENCE:

PLACE OF ACCIDENT OR OCCURRENCE (Location where Injury Occurred i.e., Department/Area)	COUNTY OF INJURY Skagit County	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	TIME WORKDAY BEGAN
	LAST WORKDATE	DATE/TIME EMPLOYER NOTIFIED		

DESCRIBE TYPE OF INJURY OR ILLNESS

TYPE OF INJURY:

BODY PART AFFECTED: (Be Specific)

DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURRED WITH DETAILS OF HOW EVENT OCCURRED

(Include name of other individuals involved, tools, objects, machinery, vapors, chemicals, radiations, unnatural motions of employee)

Employee Signature_____ Date:_____

Witness Name (If Applicable): _____ Contact Number:_____

Safety Representative:_____ **Immediate Supervisor**:_____	**Safety Notified on**: _____ **Immediate Supervisor Notified on**: _____
Safety Representatives Description/Comments/Concerns:	

Were immediate hazards mitigated?	Yes ☐	No ☐	Has the investigation been started? Reported By:_____ Date:___	Yes ☐	No ☐

PPE: (Check the appropriate PPE used.)

☐	Hard Hat	☐	Hearing Protection	☐	Respiratory/SCBA
☐	Safety Glasses/Goggles	☐	Hand Protection	☐	Fall Protection
☐	Chemical Resistant Clothing	☐	Face Shield	☐	Other
☐	FRC	☐	Steel Toed Boots		

TREATMENT PROVIDED BY: ☐ Onsite Medical Provider ☐ Other

☐ Return to Work (RTW) ☐ Other (See Medical Provider) _____
(Medical Providers Initials) & Date

SAFETY'S DETERMINATION AND SIGN OFF:

Safety Notes: (describe treatment)	☐	Work Related	
	☐	Observation	Safety Signature:
	☐	First Aid	_____
	☐	(OSHA Recordable) Medical Treatment	
	☐	(OSHA Recordable) Restricted Duty	
	☐	(OSHA Recordable) Lost Time	

REPORTING: To be completed by Safety Representative (Attached Forms)

☐	1st Aid Log	☐	Corporate Reporting (Level 3)		
☐	Incident Report Submitted	☐	Medical Provider Report (if applicable – include in employee file)	☐	Copy to HR (If applicable)
☐	Workers Compensation SIF-2 Form (If applicable – attach Washington State Self Insurer Accident Report)	☐	OSHA Database	☐	OSHA 300 Log Date entered:_____

Safety Representative Signature: Date:

Follow up needed:

Date Filed in Safety Filing System:
Date Filed with employee Medical Record: