



### Team Memembers Report of Incident



1. Partners Name, (Last, First, M. Initial) <i>Barnum, Lonnie L</i>	2. DOB <i>6-21-81</i>	3. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. Date of Injury <i>9-23-16</i>	5. Time of Injury <i>10:55</i>	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM
6. Time Partner Started Working Day of Incident:		Time: <i>6</i>	<input checked="" type="checkbox"/> AM	<input type="checkbox"/> PM	
7. Partners Social Security Number: <i>521-61-6156</i>					
8. Date Reported to TL/TA <i>9-23-16</i>					
9. Length of time employed as of date of incident.(yr/mo) <i>3days</i>					
10. Length of time in current job: <i>1 day</i>					
11. What happened to cause the incident (be specific)? <i>I had my hand too high on the Lexel bottle and the machine cut my hand.</i>					
12. Why did the incident occur? <i>My hand was too high, I was supposed to be holding it at the bottom.</i>					
13. Are there any broken bones because of this incident? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
14. What body part (s) were injured? Left or right side? <i>Left hand, right below thumb joint.</i>					
15. Describe other factors in the incident, i.e. object, substance, exposure, other people, etc. <i>The machine the squirts out the Lexel gel, no one else around</i>					
16. What could have prevented the incident? <i>Paying better attention</i>					
17. Was there a company safety policy, procedure or training in place that would have prevented the incident? <i>yes</i>					
18. Were you aware of the safety policy, procedure or training?				Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
19. Witnesses to the incident: <i>No one</i>					
20. What treatment was administered: <i>antibiotic spray, cream &amp; bandaids</i>					
21. TL in charge: <i>Ray</i>					
22. What was the specific task being performed when the incident occurred? <i>Squeezing Lexel out of bottle</i>					
I agree that the information contained in this Incident Report Form is true and accurate to the best of my knowledge. I understand that the Company will rely upon the information on this form in evaluating this claim. I understand that the assertion of a false worker's compensation claim is a violation of the State Criminal Code and may result in a fine and imprisonment and that dishonesty may lead to discipline up to and including suspension and/or termination of my employment.					
<i>Lonnie Barnum</i> Partner		<i>9-23-16</i> Date		<i>[Signature]</i> TA/TL Signature indicates you have reviewed their statements.	
<i>Lonnie Barnum</i> Partner		<i>9-23-16</i> Date		<i>[Signature]</i> TA/TL	
I was offered but chose not to seek medical attention at this time. I understand that if I feel medical attention is necessary in the future for this incident, I must notify HR prior to seeking medical attention to seek appropriate medical care.					

Print this report and have the partner fill it out in their own words. Attach the completed report to the Injury and Illness Report.