

REPORT OF MISHAP INSTRUCTIONS

I. MISHAP INFORMATION	IV. PROPERTY DAMAGE INFORMATION
<ol style="list-style-type: none"> 1. Post/Establishment – Provide Post name if overseas. Provide Establishment name if domestic. 2. City, State/Province, Country – Provide city, state/province, and country for overseas Mishaps. Provide city and state for domestic Mishaps. 3. Office/Sub-Office – Provide the office/sub-office of the injured individual or office reporting damaged property. 4. Type of Mishap – Check one or more types that apply to this Mishap. For “Environmental Contamination,” see NOTES. 5. Date of Mishap – Enter the date of Mishap as mm-dd-yyyy. For illnesses (<i>e.g., cumulative trauma</i>), enter the date of diagnosis or onset of disability, whichever is earlier. 6. Time of Mishap – Enter time as hh:mm. 7. Location of Mishap - Check all that apply. Then, briefly describe the specific location on the property (<i>e.g., office area, training center, roof, stairs, etc.</i>). 8. Detailed Description of Mishap – Describe, in as much detail as possible, the who, what, where, when, why and how of the Mishap. Include relevant remarks about weather, equipment or tools involved, unsafe conditions, acts and personal factors, and whether other persons may have contributed to the accident. For environmental Mishaps, describe the failures (<i>equipment or personnel</i>) that led to the release of chemicals or pollutants. 	<ol style="list-style-type: none"> 20. Estimated (Est.) Amount of Property Damage – Leave blank for injury/illness Mishaps. 21. Type of Property – Such as building, residence, personal property, security barrier, etc.
V. ASSIGNMENT/ACTIVITY/PPE	
	<ol style="list-style-type: none"> 22. Provide Details on the Work Assignment at the Time of the Mishap – Describe what the employee was assigned to do 23. PPE – Check the appropriate boxes if the employee was using personal protective equipment.
VI. AND VII. SIGNATURES	
<p>Both the injured individual’s supervisor and the relevant Post/Establishment/office Responsible Manager should sign the Report of Mishap. Please see MS 520 and its Procedures for the definition of Responsible Manager.</p>	
II. PERSONAL INFORMATION	FILING INSTRUCTIONS
<ol style="list-style-type: none"> 9. Name of Individual – Provide name of the injured individual. 10. Gender – Provide the gender of this individual. 11. Date of Birth – Enter the date of injured individual’s birth as mm-dd-yyyy. 12. Category and Job/Activity – For the injured individual, check one personnel category and provide their job/position title. Check the "TDY" box if the individual was on a temporary duty assignment when the Mishap occurred. 	<p>Send the completed Report of Mishap to AskOSH@peacecorps.gov.</p> <p>If the Report of Mishap cannot be completed, notify the Chief, M/AS at Peace Corps headquarters.</p>
III. INJURY/ILLNESS INFORMATION	NOTES
<ol style="list-style-type: none"> 13. Severity of Injury or Illness – Check all that apply. Hospital admission means being admitted to the hospital for at least one overnight stay resulting from the injury/illness. 14. Fatality – Enter date of death if after date of Mishap as mm-dd-yyyy. 15. Medical Treatment – For "Emergency Room" medical care, check for any instances where the patient used emergency room services. First Aid treatment (<i>i.e., one-time treatment of minor scratches, cuts, burns, splinters, etc.</i>) does not ordinarily require medical care, even if administered by a physician or registered professional. 16. Cause of Mishap – Identify the event that resulted in the injury or illness (<i>such as falling from, struck by, lifting, inhaling</i>) and the object or source involved (<i>such as ladder, tool, chemical</i>). For property damage or environmental contamination, provide the event and source leading to the damage/contamination. 17. Nature of Injury or Illness – Indicate the type of injury (<i>or property damage</i>) or illness, such as 2nd degree burn, fracture, abrasion, contusion, amputation, hearing loss, irritation, cancer, liver disease, contamination, etc. 18. Body Part(s) Injured – Indicate the body parts(s) injured, such as lower arm, ankle, ribs, neck, head, eye, hearing, liver, respiratory tract, etc. (Leave blank for property damage Mishaps). 19. Work-Related Staff Injuries ONLY: <ol style="list-style-type: none"> a. Estimated Calendar Days Lost from work – A count of all calendar days (consecutive or not), including weekend days and holidays, after, but not including, the day of injury or illness onset, where the individual would have worked but could not because of the injury or illness. b. Estimated Days Restricted Duty – The number of days when the individual could not perform any or their normal assignment during all or any part of the workday or shift, because of the injury or illness. c. Name of Treating Physician/Health Care Provider – Please provide as much information as possible. d. Treatment Facility Name and Address (if off-site) – Please provide as much information as possible. e. Staff Hire/Entry-on-Duty Date – Enter as mm-dd-yyyy. f. Shift Start Time – Enter as hh:mm. 	<p>For Mishaps causing injury or illness to more than one individual, complete and attach a separate Mishap Report form for each injured individual.</p> <p>Any fatality of a staff member which is the result of a work-related Mishap, must be reported within 8 hours per the Peace Corps MS 520 Procedures.</p> <p>All other Serious Mishaps, which include the following, must be reported within 24 hours:</p> <ul style="list-style-type: none"> • injury or occupational illness resulting in admission to a hospital, • amputation, • loss of an eye, or • loss of consciousness. <p>For environmental contamination, see definition in the MS 520 Procedures.</p>
PRIVACY ACT STATEMENT	
<p>AUTHORITY: The Occupational Safety and Health Act of 1970 (29 U.S.C. 657, 673); Secretary of Labor’s Order No. 12-71 (36 FR 8754), 8-76 (441 FR 25059), or 9-83 (48 FT 35736) and Code of Federal Regulations, Occupational Safety and Health Administration, Labor (29 1904, 1-22).</p> <p>A Report of Mishap is required whenever a Mishap occurs on US Government-owned or -leased property, or during the conduct of U.S. Government business. Reporting is required when Mishaps result in personal injury or illness, property damage, or environmental contamination.</p> <p>PURPOSE: The principal purpose of the Report of Mishap is to inform safety and health officials of all occupational injuries, illnesses, official vehicle property damage, and environmental contamination incidents. Sufficient details must be provided to ensure appropriate corrective actions are developed and implemented to help prevent future occurrences. It is also used to ensure that supervisors are aware of their safety/health responsibilities.</p> <p>ROUTINE USES: These reports are used to provide injury and illness data to the Department of Labor in the Department’s Safety and Occupational Health Annual Report. This report is designed to document and measure the progress of the safety program. Mishap reports are reviewed during program assessments and to focus training/assistance efforts on the information contained therein.</p>	

COMPLETE THIS FORM TO REPORT ALL MISHAPS RESULTING IN INJURIES, INCLUDING INJURIES FROM AGENCY VEHICLE MISHAPS, ILLNESSES, OR ENVIRONMENTAL CONTAMINATION.

<p>THE PEACE CORPS REPORT OF MISHAP</p>		<p>III. INJURY/ILLNESS INFORMATION</p>	
		<p>13. Severity of Injury or Illness (check all that apply):</p> <p align="center"> <input type="checkbox"/> Fatal <input type="checkbox"/> Hospital Admission <input type="checkbox"/> Amputation <input type="checkbox"/> Loss of Eye <input type="checkbox"/> Loss of Consciousness </p>	
<p>I. MISHAP INFORMATION</p>		<p>14. Fatal - Date of Death if After Date of Mishap (MM/DD/YEAR):</p>	
<p>1. Post/Establishment:</p>		<p>15. Medical Treatment:</p> <p align="center"> <input type="checkbox"/> Emergency Room <input type="checkbox"/> First Aid Only <input type="checkbox"/> Other: _____ </p>	
<p>2. City, State/Province, Country:</p>			
<p>3. Office/Sub-Office:</p>			
<p>4. Type of Mishap (check all that apply):</p> <p align="center"> <input type="checkbox"/> Illness/Injury <input type="checkbox"/> Property Damage <input type="checkbox"/> Environmental Contamination </p>		<p>16. Cause of Mishap:</p>	
<p>5. Date of Mishap (MM/DD/YEAR):</p>	<p>6. Time of Mishap (HH:MM):</p>		
<p>7. Location of Mishap (check all that apply):</p> <p>a. Type: <input type="checkbox"/> Office <input type="checkbox"/> Residence <input type="checkbox"/> Other: _____</p> <p>b. Specific Location: _____</p>		<p>17. Nature of Injury/Illness (contusion, laceration, sprain, fracture, muscle strain, etc.):</p>	
<p>8. Detailed Description of Mishap—What happened? (Please attach the MV Report form if a motor vehicle mishap.)</p>		<p>18. Body Part(s) Injured:</p>	
		<p>19. Work-Related Staff Injuries <u>ONLY</u>:</p> <p>a. Calendar Days Lost: _____ b. Days Restricted Duty: _____</p> <p>c. Name of Treating Physician/Health Care Provider: _____</p> <p>d. Treatment Facility Name and Address: _____</p> <p>e. Staff Hire/Entry-on-Duty Date (MM/DD/YEAR): _____</p> <p>f. Shift Start Time (HH:MM): _____</p>	
<p>II. PERSONAL INFORMATION</p>		<p>IV. PROPERTY DAMAGE INFORMATION</p>	
<p>9. Name (Last, First, Middle):</p>		<p>20. Est. Amount of Property Damage:</p>	<p>21. Type of Property:</p>
<p>10. Gender (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>11. Date of Birth (MM/DD/YEAR):</p>	<p>V. ASSIGNMENT/ACTIVITY/PPE</p>	
<p>12. a. Category (check one):</p> <p align="center"> <input type="checkbox"/> Staff (U.S. Direct-Hire, PSC, FSN) <input type="checkbox"/> CON (External/On-Site) <input type="checkbox"/> EFM <input type="checkbox"/> Visitors <input type="checkbox"/> Other: _____ </p> <p>b. Job/Position Title: _____</p> <p>c. <input type="checkbox"/> TDY</p>		<p>22. Provide Details on the Work Assignment at the Time of the Mishap — What was the employee assigned to do?</p>	
		<p>23. Was the employee wearing any PPE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply:</p> <p align="center"> <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Goggles <input type="checkbox"/> Face Shield <input type="checkbox"/> Gloves <input type="checkbox"/> Respirator <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Other: _____ </p>	
<p>VI. SUPERVISOR</p>		<p>VII. RESPONSIBLE MANAGER</p>	
<p>Name:</p>	<p>Title:</p>	<p>Name:</p>	<p>Title:</p>
<p>Signature:</p>	<p>Date (MM/DD/YEAR):</p>	<p>Signature:</p>	<p>Date (MM/DD/YEAR):</p>

SEND COMPLETED FORM TO ASKOSH@PEACECORPS.GOV.