



NEAR MISS/MISHAP REPORTING – MCCS SOUTH CAROLINA

Near Miss ☐
 Mishap Injury ☐
 Mishap Death ☐

SECTION A: PERSONAL DATA

MCCS-SC Employee ☐ Customer ☐ Military ☐

| | | | | |
|--|------|--------------------------|-----|----------|
| Name (Last, First MI) | | Affiliation | Sex | DOB |
| Mailing Address | City | State | | Zip Code |
| Phone Number Alternative Number | | Email Address (Optional) | | |

SECTION B: JOB INFORMATION

| | | | | |
|---|--|--|------|-------|
| Facility/Activity | Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Flex <input type="checkbox"/> | | Rate | Title |
| Date of Employment (MM/DD/YY) | Days Normally Worked | | | |
| Work Shift: Time in: Time Out: | Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/> | | | |

SECTION C: WITNESS INFORMATION

| | | | |
|--|------|--------------------------|----------|
| Supervisor Name (Last, First MI) | | Rank/Rate | DOB |
| Mailing Address | City | State | Zip Code |
| Phone Number Alternative Number | | Email Address (Optional) | |

| | | | | |
|--|------|--------------------------|-----|----------|
| Witness Name (Last, First MI) | | Affiliation | Sex | DOB |
| Mailing Address | City | State | | Zip Code |
| Phone Number Alternative Number | | Email Address (Optional) | | |

SECTION D: INCIDENT DATA

| | | | |
|--|---|---|--|
| Date of Incident (MM/DD/YY) | Facility where Incident Occurred: | | |
| Time of Incident <input type="checkbox"/> Exact <input type="checkbox"/> Approx. | Specific Location Where incident occurred: (Aisle 9 on back side) | | |
| Type of Mishap: | Alleged injury: | Body Part: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> N/A | |
| Chemical(s) involved? | Chemical(s) Information or comments: | | |

| | | |
|--|------------------------------------|----------|
| Was PPE required? | Was PPE used? | |
| Did customer refuse medical treatment? | Was First Aid provided? (Band-Aid) | CPR/AED? |
| Describe Incident in Detail: (Who, What, Where, Why, How) | | |
| Brief description of injured person (This will only be used for video identification purposes) | | |

SECTION E: Property Damage

| | | | |
|---|-------------------|---|-------------------|
| What Equipment was involved? | Equipment Details | DOD Property Damage? | NON DOD Property? |
| Property Details: | | Motor Vehicle involved? | |
| Vehicle 1 information: Year: Make: Model: | | Vehicle 2 information: Year: Make: Model: | |

SECTION F:

| | | |
|---------------------------------|---|---|
| Print Name (Supervisor): | Signature | Date: |
| Print Name (Employee/Customer): | Signature | Date: |
| Print Name (Witness 1): | Signature | Date: |
| Print Name (Witness 2): | Signature | Date: |
| <i>For Official Use Only</i> | | |
| File/Case #: | Is follow-up required? <input type="checkbox"/> Yes <input type="checkbox"/> No | Follow up assigned to: Is video documentation required? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Additional notes: | Controlled By: DEPARTMENT OF THE NAVY Controlled By: MCCS SC Review and Analysis Division CUI Category: PRVCY Distribution/Dissemination Control: DL ONLY POC: (843) 228-7970 or 6717 | |

SUBMIT COMPLETED REPORT USING "MCCS-SC HELP CENTER"

CUI