

Annex H
(Informative)
Eye Injury Report Form

The attached form is provided for users of occupational and educational eye and face protection. completing and returning this form will assist the Z87 Committee on Safety Standards for Eye Protection to improve this standard and develop others, as appropriate. The Eye Injury Report Form is not subject to copyright and may be reproduced as needed.

Eye Injury Report Form	
Please report all work-related and education-related eye injuries to assist the ANSI Z87 Committee on Eye and Face Protection develop improved standards. Eye injuries include injuries to the eyeball, surrounding tissue such as the lids, and the bones forming the eye socket.	
<p>1. Injured worker/student information</p> <p>Worker's/student's initials <small>(first/middle/last)</small> _____</p> <p>Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Age _____</p> <p>Job title/type of work: _____ <small>(describe in detail)</small> _____ <small>(e.g., journeyman carpenter-concrete form builder)</small></p> <p>Date of injury (mo/day/yr) ____/____/____</p> <p>Was there 1 day (8hrs) or more of lost work/school-time? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>2. Employer/Educational institution information</p> <p>Nature of business _____ <small>(describe in detail, e.g., steel ball-bearing manufacturer)</small></p> <p>Contact name _____</p> <p>Title _____</p> <p>Company name _____</p> <p>Address _____</p> <p>City _____ State ____ Zip _____</p> <p>Phone (____) _____ FAX (____) _____</p>
<p>3. Industry type <small>(check one)</small> or describe education institute</p> <p><input type="checkbox"/> Agriculture/forestry/fishing</p> <p><input type="checkbox"/> Mining</p> <p><input type="checkbox"/> Construction</p> <p><input type="checkbox"/> Manufacturing</p> <p><input type="checkbox"/> Transportation</p> <p><input type="checkbox"/> Public Utility/Sanitation</p> <p><input type="checkbox"/> Finance/Insurance/Real estate</p> <p><input type="checkbox"/> Retail/wholesale trade</p> <p><input type="checkbox"/> Services <small>(e.g., lodging/food/health/legal/social/education)</small></p> <p><input type="checkbox"/> Public Administration <small>(e.g. gov't/police/fire/safety/military)</small></p> <p><input type="checkbox"/> Other <small>(describe):</small></p>	<p>4. Part of body injured <small>(Check all that apply)</small></p> <p><input type="checkbox"/> Eyeball, one eye <input type="checkbox"/> Other tissue around eye</p> <p><input type="checkbox"/> Eyeball, both eyes <input type="checkbox"/> Bone, eye socket</p> <p><input type="checkbox"/> Eye lid <input type="checkbox"/> Other: _____</p> <hr/> <p>5. Nature of injury <small>(Check all that apply)</small></p> <p><input type="checkbox"/> Corneal scratch/abrasion <input type="checkbox"/> Thermal burn</p> <p><input type="checkbox"/> Foreign body <u>on</u> eye surface <input type="checkbox"/> Chemical burn</p> <p><input type="checkbox"/> Foreign body <u>in</u> eyeball <input type="checkbox"/> Radiation burn <small>(welder flash)</small></p> <p><input type="checkbox"/> Puncture of eyeball <input type="checkbox"/> Blunt trauma to eye</p> <p><input type="checkbox"/> Laceration to eye or lid <input type="checkbox"/> Blood in eye</p> <p><input type="checkbox"/> Facial fracture <input type="checkbox"/> Other: _____</p>

<p>6. Source of injury <i>(check one)</i></p> <p><input type="checkbox"/> Chemicals and chemical products (includes wet/dry cement mix)</p> <p><input type="checkbox"/> Containers</p> <p><input type="checkbox"/> Furniture and fixtures (includes wall/floor/window coverings)</p> <p><input type="checkbox"/> Machinery</p> <p><input type="checkbox"/> Parts and materials (includes building materials/fasteners)</p> <p><input type="checkbox"/> Persons, plants, animals, and minerals</p> <p><input type="checkbox"/> Structures and surfaces</p> <p><input type="checkbox"/> Tools, instruments, and equipment</p> <p><input type="checkbox"/> Vehicles</p> <p><input type="checkbox"/> Other sources (scrap/debris) <i>describe:</i></p>	<p>7. Injury event or exposure <i>(check one)</i></p> <p><input type="checkbox"/> Contact with objects and equipment</p> <p><input type="checkbox"/> Falls</p> <p><input type="checkbox"/> Bodily reaction and exertion</p> <p><input type="checkbox"/> Exposure to harmful substance or environments</p> <p><input type="checkbox"/> Transportation accidents</p> <p><input type="checkbox"/> Fires and explosions</p> <p><input type="checkbox"/> Assaults and violent acts</p> <p><input type="checkbox"/> Other events or exposures <i>(describe):</i></p>																								
<p>8. At the time of the injury was the worker/student wearing <u>any</u> of the following items: prescription glasses, contact lenses, sunglasses, or safety eye and face protection (e.g., safety glasses, goggles, face shield, welding helmet)?</p> <p><i>(check one)</i> <input type="checkbox"/> Yes <i>(go to question 9)</i> <input type="checkbox"/> No <i>(skip to question 12)</i> <input type="checkbox"/> Unknown <i>(skip to question 12)</i></p>																									
<p>9. What vision aids and/or eye protection were worn at the time of the injury? <i>(Check <u>all items</u> that were worn)</i></p> <table border="0"> <tr> <td><input type="checkbox"/> Prescription glasses (non-safety)</td> <td><input type="checkbox"/> Goggles—direct vented</td> <td><input type="checkbox"/> Face shield—plastic</td> </tr> <tr> <td><input type="checkbox"/> Contact lenses</td> <td><input type="checkbox"/> Goggles—indirect vented</td> <td><input type="checkbox"/> Face shield—wire mesh</td> </tr> <tr> <td><input type="checkbox"/> Sunglasses (non-safety)</td> <td><input type="checkbox"/> Goggles—non vented</td> <td><input type="checkbox"/> Face shield—plastic mesh</td> </tr> <tr> <td><input type="checkbox"/> Prescription safety glasses with side shields</td> <td><input type="checkbox"/> Goggles—venting unknown</td> <td><input type="checkbox"/> Welding helmet</td> </tr> <tr> <td><input type="checkbox"/> Prescription safety glasses—no side shields</td> <td><input type="checkbox"/> Cup goggles</td> <td><input type="checkbox"/> Welding goggles</td> </tr> <tr> <td><input type="checkbox"/> Non-prescription safety glasses with side protection</td> <td><input type="checkbox"/> Wire mesh goggles</td> <td><input type="checkbox"/> Full-face respirator</td> </tr> <tr> <td><input type="checkbox"/> Non-presc. safety glasses—no side protection</td> <td><input type="checkbox"/> Laser goggles</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Non-presc. safety glasses—side protection unknown</td> <td><input type="checkbox"/> Other <i>(describe):</i></td> <td></td> </tr> </table> <p><i>Complete other side</i></p>		<input type="checkbox"/> Prescription glasses (non-safety)	<input type="checkbox"/> Goggles—direct vented	<input type="checkbox"/> Face shield—plastic	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Goggles—indirect vented	<input type="checkbox"/> Face shield—wire mesh	<input type="checkbox"/> Sunglasses (non-safety)	<input type="checkbox"/> Goggles—non vented	<input type="checkbox"/> Face shield—plastic mesh	<input type="checkbox"/> Prescription safety glasses with side shields	<input type="checkbox"/> Goggles—venting unknown	<input type="checkbox"/> Welding helmet	<input type="checkbox"/> Prescription safety glasses—no side shields	<input type="checkbox"/> Cup goggles	<input type="checkbox"/> Welding goggles	<input type="checkbox"/> Non-prescription safety glasses with side protection	<input type="checkbox"/> Wire mesh goggles	<input type="checkbox"/> Full-face respirator	<input type="checkbox"/> Non-presc. safety glasses—no side protection	<input type="checkbox"/> Laser goggles		<input type="checkbox"/> Non-presc. safety glasses—side protection unknown	<input type="checkbox"/> Other <i>(describe):</i>	
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<p>10. How was the worker/student injured while wearing the item(s) checked in question 9?</p> <p><i>(check one)</i></p> <table border="0"> <tr> <td><input type="checkbox"/> Object/chemical went around glasses/protector</td> <td><input type="checkbox"/> Frame broke & caused injury</td> </tr> <tr> <td><input type="checkbox"/> Object went through glasses/protector</td> <td><input type="checkbox"/> Lens shattered & entered eye</td> </tr> <tr> <td><input type="checkbox"/> Object/impact forced glasses/protector into eye</td> <td><input type="checkbox"/> Lens was knocked out of frame</td> </tr> <tr> <td><input type="checkbox"/> Glasses/protector was knocked off</td> <td><input type="checkbox"/> Glasses/protector were lifted up/not in proper position</td> </tr> <tr> <td><input type="checkbox"/> Other <i>(describe):</i></td> <td></td> </tr> </table>		<input type="checkbox"/> Object/chemical went around glasses/protector	<input type="checkbox"/> Frame broke & caused injury	<input type="checkbox"/> Object went through glasses/protector	<input type="checkbox"/> Lens shattered & entered eye	<input type="checkbox"/> Object/impact forced glasses/protector into eye	<input type="checkbox"/> Lens was knocked out of frame	<input type="checkbox"/> Glasses/protector was knocked off	<input type="checkbox"/> Glasses/protector were lifted up/not in proper position	<input type="checkbox"/> Other <i>(describe):</i>															
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<p>11. If the safety eye protection was damaged in the injury event, what type of material was damaged?</p> <p><i>(Check all that apply)</i></p> <p><input type="checkbox"/> Polycarbonate plastic lens/shield</p> <p><input type="checkbox"/> Acrylic plastic lens/shield</p> <p><input type="checkbox"/> CR39 or Hi-Index plastic lens</p> <p><input type="checkbox"/> Other or unknown-type plastic lens/shield</p> <p><input type="checkbox"/> Glass lens</p> <p><input type="checkbox"/> Wire or plastic mesh lens/shield</p> <p><input type="checkbox"/> Plastic frame/headgear</p> <p><input type="checkbox"/> Metal frame/headgear</p> <p><input type="checkbox"/> Other <i>(describe):</i></p>	<p>12. Describe the medical treatment required other than simple first aid:</p> <p><i>(Check all that apply)</i></p> <p><input type="checkbox"/> Emergency department visit</p> <p><input type="checkbox"/> Physician/clinic visit</p> <p><input type="checkbox"/> Eye specialist visit</p> <p><input type="checkbox"/> Eye surgery—repair or removal of an object</p> <p><input type="checkbox"/> Eye surgery—removal of the eye</p> <p><input type="checkbox"/> Hospitalization (≥24hrs)</p> <p><input type="checkbox"/> Other <i>(describe):</i></p> <p>Was there a permanent loss of vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																								

- Checklist of narrative items to include:**
- ✓ **Eye protection worn**
 - ✓ **If safety eye protection failed, why?**
 - ✓ **Type of work being done** (general)
 - ✓ **Specific task**
 - ✓ **Bystander or helper**
 - ✓ **Equipment/tools used**
powered? hand tool?
 - ✓ **Materials handled or worked with** (e.g., type of material, sawing, welding or grinding)
 - ✓ **Location**
inside/outside—if outside, weather & lighting; type of structure
 - ✓ **Type of Injury**
struck by flying object; welding burn (UV); blunt trauma; chemical splash; assault; vehicle accident (airbag injury)
 - ✓ **Nature of Injury**
foreign body, corneal

13. Please describe how the eye injury occurred including the job at the time, equipment that was used, where the work was done, the type of injury, and any other factors which may have contributed to the injury. A detailed company incident report may be attached in place of this narrative.

Use additional paper if necessary

14. Return form to:

ANSI Accredited Z87 Committee
c/o American Society of Safety Engineers
1800 East Oakton Street
Des Plaines, IL 60018

If safety eye protection was damaged in the incident, please include photographs or the eye protection device, if available.
Thank you for your assistance in helping prevent eye injuries among American workers and students.