

Name of Entity

Employee Work Related Accident / Incident Analysis Report

PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION AND RETURN TO NAME OF DEPT/TITLE OF RESPONSIBLE INDIVIDUAL WITHIN 24 HOURS FROM THE TIME OF INJURY.

Employee Name: _____	Location: _____
Job Title: _____	Date of Hire: _____
Date of Accident/Incident: _____	Time of Accident/Incident: _____
Date Reported: _____	To Whom Reported: _____
Dates of Work Lost: _____	Supervisor: _____
Accident /Incident Location: _____	801 Claim Form Filed? Y () N ()

Complete if medical treatment sought or time lost from work

Parts of Body Affected		
<u>Head/Neck</u>	<u>Left Side</u>	<u>Right Side</u>
() Scalp	()	()
() Neck	()	()
() Ears	()	()
() Eyes	()	()
() Mouth	()	()
() Teeth	()	()
() Face	()	()
<u>Upper Extremities</u>	<u>Left Side</u>	<u>Right Side</u>
() Shoulder	()	()
() Upper Arm	()	()
() Elbow	()	()
() Forearm	()	()
() Wrist	()	()
() Hand	()	()
() Fingers	()	()
<u>Lower Extremities</u>	<u>Left Side</u>	<u>Right Side</u>
() Thigh	()	()
() Lower Leg	()	()
() Knee	()	()
() Ankle	()	()
() Foot/Toes	()	()
<u>Trunk</u>	<u>Left Side</u>	<u>Right Side</u>
() Lower Back	()	()
() Upper Back	()	()
() Chest	()	()
() Abdomen	()	()
() Hip	()	()
() Groin	()	()

Nature of Injury	
() Cut	() Foreign Body in Eye or Sliver
() Scrape	() Burn
() Bruise	() Electric Shock
() Skin Rash	() Difficulty Breathing
() Numbness	() Pain in Body Part Identified at Left
() Inflammation	() Dizziness
() Jammed Finger	() Other: _____
or Toe	

Contributing Factors
() Machinery Defect (Save defective parts & pieces)
() Tool or Equipment Broke (Save broken parts & pieces)
() Equipment Guarding
() Proper Tools/Equipment Not Available
() Floor, Work Surface, or Walking Surface
() Housekeeping
() Lighting
() Clothing or Jewelry
() Improper Ergonomics
() Other: _____

Work Behavior At Time of Injury
<i>(Please check all items that pertain)</i>
() Lifting
() Carrying
() Reaching
() Pushing
() Pulling
() Bending or Twisting (circle correct item)
() Running
() Stepping (walking or moving from one level to another)
() Typing / Office Related Repetitive Motion
() Other Repetitive Motion Tasks
() Jumping
() Driving (If so, what vehicle?)
() Operating Equipment
() Innocent Bystander
() Other _____

Names of Witnesses: (Please provide witness information on a separate sheet of paper)

Safety Equipment/ Personal Protective Equipment In Use At Time of Accident/Incident:

Describe what happened (include sequence of events; equipment, materials, and substances being used; and environment – PLEASE BE SPECIFIC): _____

How long have you been doing this particular job?: _____

Have you had any similar incidents in the past? Yes _____ No _____ (If yes, please describe by including date, type of incident, and if any action was taken): _____

Have you injured this part(s) of your body previously or is there any pre-existing condition that could affect the injury? Yes _____ No _____ (if yes, please explain): _____

What do you think can be done to prevent this incident from reoccurring? _____

To Be Completed By Employee's Supervisor:

Why did the accident/incident happen or the condition exist? _____

What could have been done, or should be done, to prevent this accident/incident?: _____

Have there been accidents or incidents in this same activity? Was action taken? _____

****Please Provide Witness Information On A Separate Piece of Paper****

Employee's Signature: _____

Date: _____

Supervisor's Signature: _____

Date: _____

Risk Manager's Signature: _____

Date: _____

SAFETY COMMITTEE EVALUATION OF ACCIDENT/INCIDENT

Corrective Action Needed: _____

Corrective Action Assigned To (if applicable): _____

Date Corrective Action Completed: _____

Committee Recommendations: _____

