04/08/98

# PUBLIC ALLIANCE INSURANCE COVERAGE FUND
# EMPLOYEE ACCIDENT INVESTIGATION REPORT FORM

**THIS SECTION OF THE ACCIDENT REPORT IS TO BE FILLED OUT BY A RESPONSIBLE INDIVIDUAL IN THE ENTITY WHO HAS THE ACCIDENT REPORTED TO THEM.**

| | | | |
|---|---|---|---|
| **ENTITY:** | **PHYSICAL LOCATION OF ACCIDENT:** _____ | **Date of Accident:** _ ___/____/____ | **Time: _____AM _____ PM** |

**EMPLOYEE?S NAME: _____ SOCIAL SECURITY #: _____ - _____ - _____**

| | | |
|---|---|---|
| **JOB TITLE:** _____ | **DEPARTMENT:**_____ | **TIME IN CURRENT JOB?** _____**YRS. _____MOS.** |
| **HRS. WORKED IN PREVIOUS 24 HR. PERIOD? _____ _____** | **TREATMENT: ____ First Aid ____ Medical Visit ____ Hospitalization (Notify PEOSHA)** | |
| **EMPLOYEE BACK WORK? ____ YES ____ NO** | **DATE RETURNED:_____ / _____ / _____** | **REGULAR DUTY? _____ LIGHT DUTY?** _____ |

| | |
|---|---|
| **WITNESS TO ACCIDENT:** | **NAME: _____STREET ADDRESS:_____**<br>**CITY/TOWN _____ STATE: _____ ZIP: _____**<br>**PHONE - HOME : _____ BUS: _____ IF EMPLOYEE: DEPARTMENT:_____** |

**THIS SECTION OF THE REPORT IS TO BE FILLED OUT BY THE INJURED PARTY:**

IN YOUR OWN WORDS DESCRIBE WHAT HAPPENED.

_____

_____

_____

_____ _____

SIGNATURE DATE

**THIS SECTION OF THE REPORT IS TO BE FILLED OUT BY THE INJURED EMPLOYEE?S SUPERVISOR.**

**ACCIDENT DETAILS: (When answering the questions that follow, bear in mind that it is important to get to the root cause of the accident. So investigate the situation throughly. Do not settle for obvious answer.**

**DATE OF THIS REPORT: _____/_____/_____**
**DESCRIBE WHAT HAPPENED.**

_____

_____

_____

**DESCRIBE THE RESULTING INJURY AND ANY PROPERTY DAMAGE.**

_____

_____

**WHAT WAS THE INJURED PARTY DOING JUST PRIOR TO AND AT THE TIME OF THE ACCIDENT.**

_____

_____

**WHAT ACTIONS OR CONDITIONS MAY HAVE CONTRIBUTED TO THIS ACCIDENT?**

_____

_____

**HAVE THERE BEEN ANY SIMILAR ACCIDENTS OF THIS TYPE IN THE PAST? YES_____ NO_____ IF YES, DESCRIBE BELOW.**

_____

_____

**WERE WRITTEN OR ACCEPTED SAFE METHODS & PRACTICES FOLLOWED PRIOR TO ACCIDENT? IF NOT, EXPLAIN BELOW.**

_____

_____

**THIS SECTION IS FOR CLASSIFICATION PURPOSES. PLEASE CHECK THE BOX THAT MOST CLOSELY DESCRIBES WHAT HAPPENED.**

**Type of Accident**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Caught In/Between | | Struck By | | Struck Against | | Slip/Trip | | Fall - Same Level |
| | Fall-Elevation | | Collision/Upset of Vehicle | | Pushing or Pulling | | Lifting, Carrying, Reaching | | Twisting, Bending, Stretching |
| | Contact With | | Cut, Puncture, Scrape | | Walk/ Run/Jump | | Cumulative Trauma | | Exposure To: |
| | Ingestion | | Inhalation | | Skin Absorption | | Other:_____ | | |

**Agency of Accident**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Machinery | | Power Hand Tool | | Ladder/Scaffold/Elev. | | Materials/Supplies | | Hot Objects/Liquids |
| | Floor | | Stairs/Ramps | | Elevator | | Human | | Walkway |
| | Road/Parking Lot | | Chemical | | Pool/Lake/Pond | | Snow/Ice/Water | | Electrical |
| | Chemical | | Vehicle | | Power Equip. | | Grease/Oil | | Ground (Grass/Other) |
| | Pressure Vessel | | Foreign Body | | Furniture/Office Equip. | | Elec. Cords | | Animal/Inspect/Plant |
| | Infectious Mat?l. | | Police Equip. | | Weapon | | Bldg. Fixtures/Fence | | Temp. Extremes |
| | Sharp Object | | Mobil Equip. | | Hole/Ditch/Excavation | | Garbage/Recyclable | | Smoke/Fume/Vapor |
| | Hand Tool | | Needle/Med. Inst. | | Sports/Fitness Equip. | | Mechanical Equip. | | Other_____ |

**Body Part Affected**:

| **Head & Neck** | | **Upper Extremities** | | **Body** | | **Lower Extremities** | |
|---|---|---|---|---|---|---|---|
| | Head | | Shoulder R - L | | Back/Spine | | Hip R - L |
| | Scalp/Skull | | Upper Arm R - L | | Chest | | Thigh R - L |
| | Eye(s) R - L | | Elbow R - L | | Abdomen | | Knee R - L |
| | Ear(s) R - L | | Forearm R - L | | Groin | | Lower Leg R - L |
| | Nose | | Wrist R - L | | Body-Multiple | | Ankle R - L |
| | Face | | Hand R - L | | Internal Organs | | Foot R - L |
| | Mouth | | Fingers/ Thumb R - L | | Buttocks | | Toe(s) |
| | Neck/Throat | | Multiple | | Vascular/Nervous System | | Multiple |

**Type of Injury**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Laceration | | Puncture | | Concussion | | Contusion |
| | Hernia/Rupture | | Dislocation/Joint Injury | | Strain/Sprain/Tendinitis | | Poisoning |
| | Shock (Elec.) | | Fracture | | Abrasion | | Hearing Loss |
| | Burn | | Burn (Chemical) | | Dermatitis | | Heat Exhaustion |
| | Irritation/Inflammation | | Amputation | | Exposure | | Asphyxia/Respiratory Distress |
| | Insect Bite | | Crushing | | Paralysis | | Drowning |
| | Allergic Reaction | | Mental | | Disease/Illness/Infection | | Other:_____ |

**IN YOUR OPINION, WHAT CAUSED THIS ACCIDENT?**

_____

_____

**CORRECTIVE ACTION**

**COULD THE ACCIDENT/INCIDENT HAVE BEEN PREVENTED? IF SO, HOW?**

_____

_____

**WHAT ACTIONS HAVE BEEN, OR SHOULD BE, TAKEN TO REDUCE THE LIKELIHOOD OF ACCIDENTS OF THIS NATURE FROM RECURRING?**

_____

_____

_____ _____

Supervisor'ss Signature Reviewed by: (For the Safety Committee)

HAS CORRECTIVE ACTION BEEN TAKEN? YES ___ NO ___ If yes, date _____/_____/_____