



Personal Injury/Accident/Incident Investigation Report

Instructions: Form to be completed by the supervisor except where indicated. Report the injury immediately to Human Resources (within 24 hours).

Employee Information

Note: The Employee should fill out a report found at the end of this document

Form with fields: Name, Title, Department, Date of Hire, Date of Event, Time of Event, Hours Worked this Week, Time the Work Day Began.

Supervisor Information

Form with fields: Name, Title, Department, Date Injury Reported to Supervisor, Time Injury Reported to Supervisor, Did you visit the site?, Did you take photos?

Accident Investigation

Have similar incidents occurred in the past? [] Y [] N [] Unknown

If yes, explain why past corrective action was not effective:

Were there any witnesses? [] Y [] N Note: Each witness should fill out a witness report found at the end of this document

If yes, give name(s):

Name: _____ Phone: _____

Name: _____ Phone: _____

If additional space is needed please use the back of this sheet

Accident Type (Check all that apply)

Form with checkboxes for: Auto Accident, Slip/Trip/Fall (on same level), Slip/Trip/Fall (two or more levels), Bodily Reaction (i.e. rash, etc), Caught In or Between, Struck By or Against, Contact with Sharp Object, Repetitive Motion, Overexertion and/or lifting (strain), Strain or Sprain, Exposure to BBP or Hazardous Waste, Other - Specify:

Location where the Accident Occurred

Form with checkboxes for: Department, City/ Street, Other non work area, explain, Training - Explain (City, State, Zip, etc.)

Type of Treatment

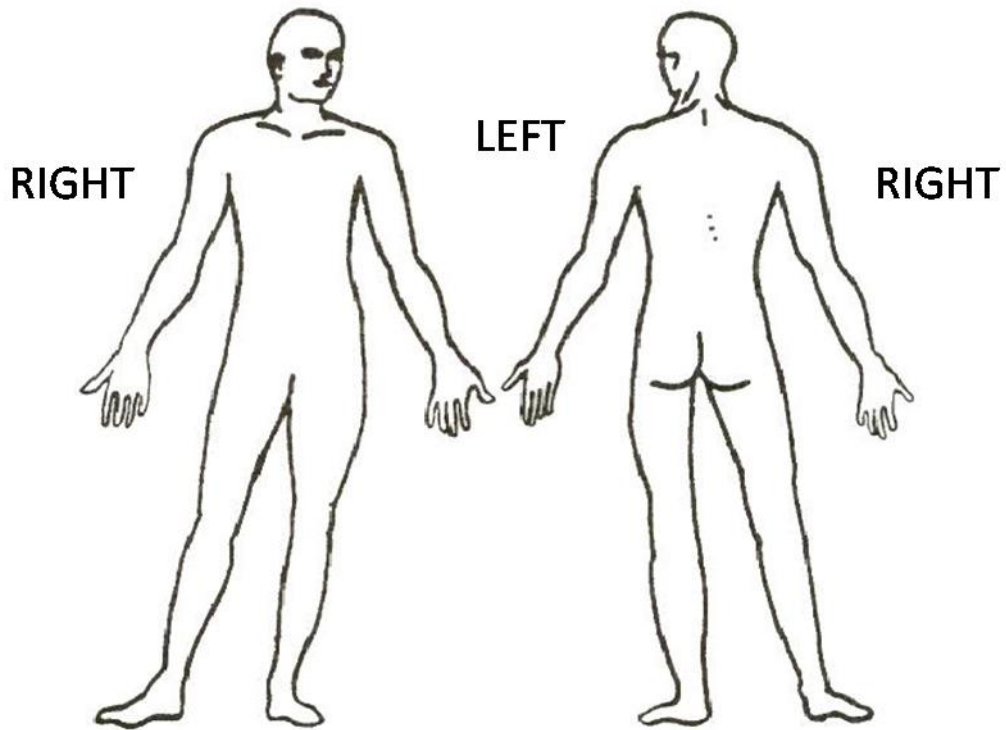
Form with checkboxes for: Emergency Room, Clinic, Long Term Care, Declined Treatment

Form with checkboxes for: First Aid Administered, Additional Information:



Body Part Affected (Check all that apply)								
Head & Neck		Upper Extremities			Body		Lower Extremities	
<input type="checkbox"/> Scalp	<input type="checkbox"/> Ears	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Arms (Upper)	<input type="checkbox"/> Back	<input type="checkbox"/> Hips	<input type="checkbox"/> Thigh		
<input type="checkbox"/> Eyes	<input type="checkbox"/> Face	<input type="checkbox"/> Elbow	<input type="checkbox"/> Forearm	<input type="checkbox"/> Chest	<input type="checkbox"/> Legs	<input type="checkbox"/> Knee		
<input type="checkbox"/> Neck	<input type="checkbox"/> Skull	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ankle	<input type="checkbox"/> Feet		
<input type="checkbox"/> Mouth	<input type="checkbox"/> Other	<input type="checkbox"/> Finger and Thumb	<input type="checkbox"/> Other	<input type="checkbox"/> Groin	<input type="checkbox"/> Toes	<input type="checkbox"/> Other		
<input type="checkbox"/> Other:				<input type="checkbox"/> None:				

Please indicate body parts affected by shading the appropriate area(s):





KANSAS EASTERN REGION INSURANCE TRUST

Preventing Loss & Promoting Safety

Please draw a diagram of the event site if applicable:



Causes – Check all possible causes, then ask “WHY?” after each one to get to the Root Cause	
People	Environment
<input type="checkbox"/> Procedures not followed or understood	<input type="checkbox"/> Poor housekeeping
<input type="checkbox"/> Using tools or equipment improperly	<input type="checkbox"/> Warning signs, lights, or horns inadequate or missing
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fire or explosion hazards
<input type="checkbox"/> Body positioned incorrectly or non-ergonomically	<input type="checkbox"/> Temperature (very hot or very cold)
<input type="checkbox"/> Rushing or working at an unsafe speed	<input type="checkbox"/> Protruding object hazard
<input type="checkbox"/> Failure to properly lock-out or tag-out equipment	<input type="checkbox"/> Slippery floor or steps
<input type="checkbox"/> Frustration or mental stress	<input type="checkbox"/> Hazardous atmospheric or other environmental hazards
<input type="checkbox"/> Removing or bypassing safety guards or devices	<input type="checkbox"/> Unsafe material placement or storage
<input type="checkbox"/> Using known defective tools or equipment	<input type="checkbox"/> Tripping hazards
<input type="checkbox"/> Job knowledge or skill deficiency	<input type="checkbox"/> Indoor air quality issues
<input type="checkbox"/> Complacency	<input type="checkbox"/> Icy conditions outside
<input type="checkbox"/> Failure to wear personal protective equipment	<input type="checkbox"/> Lighting inadequate
<input type="checkbox"/> Unprofessional behavior – Distracting, teasing, horseplay	<input type="checkbox"/> Other – specify:
<input type="checkbox"/> Other – specify:	
Equipment	Procedures
<input type="checkbox"/> Missing or inadequate machine guards	<input type="checkbox"/> No procedures or policies in place
<input type="checkbox"/> Pinch-point or other clearance hazard	<input type="checkbox"/> Procedures wrong or incomplete
<input type="checkbox"/> Defective tools or equipment	<input type="checkbox"/> Self-inspections not performed or infrequent
<input type="checkbox"/> Tools or equipment lacking ergonomic design	<input type="checkbox"/> Hazards not identified (no Job Safety Analysis)
<input type="checkbox"/> Sharp edges	<input type="checkbox"/> No training or incomplete training
<input type="checkbox"/> Preventative maintenance not performed on equipment	<input type="checkbox"/> Training not understood or demonstrated
<input type="checkbox"/> Equipment or tools stored improperly	<input type="checkbox"/> Training not regularly reinforced
<input type="checkbox"/> Equipment safety warning system inoperative	<input type="checkbox"/> Procedures not enforced by manager
<input type="checkbox"/> Other – specify:	<input type="checkbox"/> Other – specify:
Root Cause After asking “WHY?” for each cause checked above, describe the root cause(s)	
Corrective Action	
Based on the root cause(s), what have you done or plan to do to prevent a similar reoccurrence? The Hierarchy of Controls listed below are in order as most effective to least effective. Be specific in your actions and comments.	
1) Elimination/Substitution:	
2) Engineering Controls:	
3) Warnings (audible & visual):	
4) Training/Procedures:	
5) Personal Protective Equipment:	
Corrective action completed? <input type="checkbox"/> Y <input type="checkbox"/> N If not, expected completion date:	
What was the corrective action taken?	



Injured Employee Written Statement: Describe in detail how the injury occurred.

1. Location where accident occurred:

2. What were you doing with the injury occurred?

3. Name substance or object that directly caused injury:

4. Describe the nature of the injury (puncture, burn, strain, or etc.):

5. Body part affected by injury:

6. Were you using all safe guards provided?

7. Were you engaging in any unsafe acts? Unsafe lifting, horseplay, or etc.:

8. Were there any hazardous conditions at the time of injury? Defective tools, poor housekeeping, or etc.:

9. Were there any contributing factors that may have caused the injury? Lack of knowledge, Act of other than injured, or etc.:

10. What could have been done differently to have prevented this accident?

11. Additional Comments:



Witness Written Statement:

Name: _____ Phone: _____

1. Location of employee when accident occurred:

2. What was employee doing when injured?

3. Name substance or object that directly caused injury:

4. Describe the nature of the injury. Puncture, burn, strain, or etc.:

5. Employee's body part affected by injury:

6. Was employee using all safe guards provided?

7. Did you witness any unsafe acts? Unsafe lifting, horseplay, or etc.:

8. Were there any hazardous conditions at the time of injury? Defective tools, poor housekeeping, or etc.:

9. Were there any contributing factors that may have caused the injury? Lack of knowledge, Act of other than injured, or etc.:

10. What could have been done differently to have prevented this accident?

11. Additional Comments:



THE COMPLETED ACCIDENT REPORT SHOULD BE ROUTED TO:

1. TO BE FILLED OUT BY THE DEPARTMENT SAFETY REP./SAFETY COMMITTEE MEMBER:

COMMENTS:

FOLLOW UP REQUIRED:

SIGNATURE

DATE

2. TO BE FILLED OUT BY THE DEPARTMENT HEAD (if different than the supervisor):

COMMENTS:

FOLLOW UP REQUIRED:

SIGNATURE

DATE

3. TO BE FILLED OUT BY THE CITY ADMINISTRATOR/COUNTY ADMINISTRATOR:

COMMENTS:

FOLLOW UP REQUIRED:

SIGNATURE

DATE

4. TO BE FILLED OUT BY HUMAN RESOURCES:

COMMENTS:

FOLLOW UP REQUIRED:

SIGNATURE

DATE

5. ROUTED TO SAFETY COMMITTEE ON: _____
DATE

FOLLOW UP ASSIGNED TO: _____
PERSON'S NAME DATE