KERIT KANSAS EASTERN REGION INSURANCE TRUST

Preventing Loss & Promoting Safety

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*		
Name:	**Date of Event:**	
Title:	**Time of Event:**	
Department:	**Hours Worked this Week:**	**Time the Work Day Began:**
Date of Hire:		

Supervisor Information	
Name:	**Date Injury Reported to Supervisor:**
Title:	**Time Injury Reported to Supervisor:**
Department:	
Did you visit the site? ☐ Y ☐ N	**Did you take photos?** ☐ Y ☐ N

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)

☐ 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

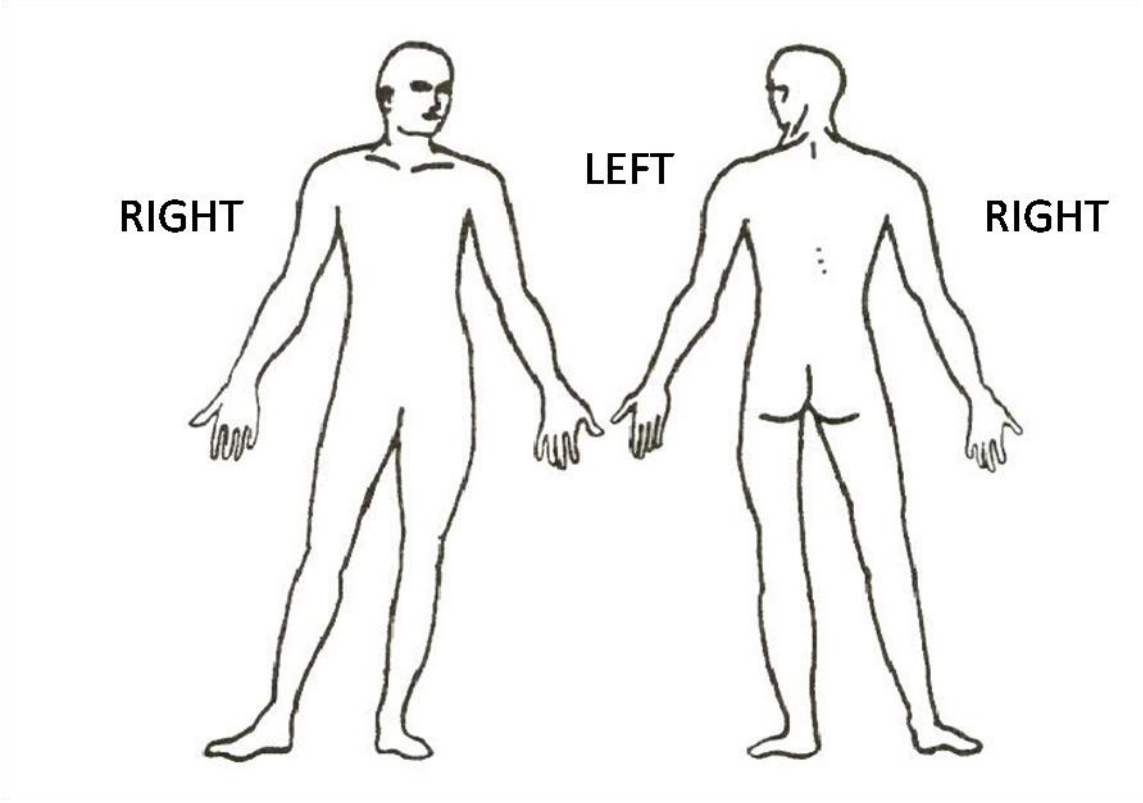
☐ Department:	☐ City/ Street:	☐ Other non work area, explain:	☐ Training – Explain (City, State, Zip, etc.)

Type of Treatment

☐ Emergency Room	☐ Clinic	☐ Long Term Care	☐ Declined Treatment
☐ First Aid Administered By:	Additional Information:		

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

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



Please draw a diagram of the event site if applicable:

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Causes – *Check all possible causes, **then ask "WHY?"** after each one to get to **the Root Cause***	
People	**Environment**
☐ Procedures not followed or understood	☐ Poor housekeeping
☐ Using tools or equipment improperly	☐ Warning signs, lights, or horns inadequate or missing
☐ Fatigue	☐ Fire or explosion hazards
☐ Body positioned incorrectly or non-ergonomically	☐ Temperature (very hot or very cold)
☐ Rushing or working at an unsafe speed	☐ Protruding object hazard
☐ Failure to properly lock-out or tag-out equipment	☐ Slippery floor or steps
☐ Frustration or mental stress	☐ Hazardous atmospheric or other environmental hazards
☐ Removing or bypassing safety guards or devices	☐ Unsafe material placement or storage
☐ Using known defective tools or equipment	☐ Tripping hazards
☐ Job knowledge or skill deficiency	☐ Indoor air quality issues
☐ Complacency	☐ Icy conditions outside
☐ Failure to wear personal protective equipment	☐ Lighting inadequate
☐ Unprofessional behavior – Distracting, teasing, horseplay	☐ Other – specify:
☐ Other – specify:	
Equipment	**Procedures**
☐ Missing or inadequate machine guards	☐ No procedures or policies in place
☐ Pinch-point or other clearance hazard	☐ Procedures wrong or incomplete
☐ Defective tools or equipment	☐ Self-inspections not performed or infrequent
☐ Tools or equipment lacking ergonomic design	☐ Hazards not identified (no Job Safety Analysis)
☐ Sharp edges	☐ No training or incomplete training
☐ Preventative maintenance not performed on equipment	☐ Training not understood or demonstrated
☐ Equipment or tools stored improperly	☐ Training not regularly reinforced
☐ Equipment safety warning system inoperative	☐ Procedures not enforced by manager
☐ Other – specify:	☐ 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? ☐ Y ☐ N If not, expected completion date:

What was the corrective action taken?

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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:

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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:

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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