

SOUTHERN ADVENTIST UNIVERSITY

Supervisor Accident Investigation Report

Everyone needs to work together and make every effort to minimize on-the-job injuries. If an injury does occur, it is important that Supervisors follow appropriate procedures to get timely medical care and conduct a thorough investigation to ultimately prevent future accidents. As soon as any needed medical needs are addressed, complete your review at the accident scene. Investigating incidents thoroughly helps us identify root causes and take corrective action to reduce the likelihood of repeat occurrences. The purpose of this review is not to assign blame, but rather to find facts. Safely secure the scene. Be prepared to take photos, measure, gather evidence, refer to written standards, and have witnesses complete written statements, etc. Determine: who, what, where, when, how, and why? Then assess what corrective actions should be taken, assign responsibility for those actions, and follow up on their completion. This form is intended for internal use and not to be used to report claims.

Report Completed by: (Supervisor):

Date:

Name of Injured Employee Job Title Employee Classification Branch/Jobsite Location of Injury
 FT PT Temp

Injured Employee's Department Date & Time Injury Occurred Supervisor Date & Time Reported to Supervisor

Task Performed when Injured Exact Location of Injury Occurrence Was Task (Check One): How long Employed?
 Routine Infrequent New

When Did Injury Occur in Shift (Check One) Occurred on Company Premises? Injured Employee Experience in Job Task (Check One)
 Early Near Break Late OT Yes No New Novice Competent Expert Unauthorized

Date On-Scene Observation of Accident Site made by Supervisor? Photos/Sketches Taken? Any Witnesses? Accident Evidence Secured?
 Yes No Yes No Yes No Yes No

Was Post-Accident Drug Testing Administered: If Yes, Where? Physician/Hospital Authorized by Employer? Name
 Yes No Yes No

Has the injured employee and medical provider been informed that **transitional duty work** will be offered for immediate return to work within medical restrictions? Yes No Additional Comments:

Nature of Injury and Body Parts Affected: (e.g., cut left thumb, broke right arm, strained lower back, etc.)

Severity of Injury/Illness.

Work Status Following Initial Medical Treatment (Anticipated)

- | | |
|--|---|
| <input type="checkbox"/> "Near-Miss" Accident (no injury) | <input type="checkbox"/> Full Duty Return to work on next shift |
| <input type="checkbox"/> First-Aid (in house treatment only) | <input type="checkbox"/> Transitional Duty Return to work on next shift |
| <input type="checkbox"/> Minor Medical (initial doctor treatment, then release) | <input type="checkbox"/> Lost Time (did not return to work on next shift) |
| <input type="checkbox"/> Serious (partial disability, continuing medical care) | |
| <input type="checkbox"/> Catastrophic (hospitalization, critical condition, severe disability, fatality) | |

Cause of Injury/Illness.

- | | | |
|--|---|---|
| <input type="checkbox"/> Slip/Trip/Fall onto same level | <input type="checkbox"/> Struck-Against (hit on, bumped into) | <input type="checkbox"/> Contact With (Electrical, Chemical, Heat/Cold) |
| <input type="checkbox"/> Fall from above level (ledge, platform, ladder, stairs) | <input type="checkbox"/> Struck By (hit by something/someone) | <input type="checkbox"/> Foreign Material in Eye |
| <input type="checkbox"/> Caught In/On/Between (pinched, snagged, grabbed) | <input type="checkbox"/> Repetitive Motion Condition | <input type="checkbox"/> Bio-hazard Exposure (needle stick, blood) |
| <input type="checkbox"/> Overexertion (strain from force, exhaustion) | <input type="checkbox"/> Vehicle Accident | <input type="checkbox"/> Animal/Insect Bite |
| <input type="checkbox"/> Respiratory Exposure | <input type="checkbox"/> Cut by sharp object (knife, blade) | <input type="checkbox"/> Other |

Describe in Detail How the Accident Occurred.

Comment on equipment/tools, materials, people, vehicles, or environmental factors (such as noise, lighting, heat, cold, etc.) that may have contributed.

Protective Gear Used by Injured Employee (when incident occurred).

Specify any PPE worn at time of incident (e.g., hard hat, face shield, fall protection harness, respirator, gloves, etc.).

Immediate Causes of Accident (identify both behavior(s) and conditions(s). Check as many as applicable.

Behaviors/Work Practices

- Using Improper Equipment (wrong type/damaged)
- Abuse or Misuse of Equipment
- Removing Safety Devices or Making them Inoperable
- Failing to Use PPE or Seatbelts

Physical Conditions

- Inadequate Guards/Barriers/Safety Devices
- Inadequate or Improper Protective Equipment
- Defective/Worn Tools or Equipment in Service
- Congested/Restricted Area/No Separation

- Improper Placement or Storage of Materials (unstable)
- Improper Handling Technique (help, grip, reach, posture)
- Failure to Use Safe Lift Handling Equipment (carts, lifts, etc.)
- Patient Handling/Improper Body Position or Overreaching
- Working on Equipment in Motion
- Performing Work at Unsafe Speed or Pace
- Not Authorized or Qualified to Perform Task
- Failure to Isolate/Secure/Lockout Energized Equipment
- Horseplay
- Inadequate Ventilation
- Drug/Alcohol Abuse

- Fire or Explosion Hazard
- Working Surface Unsafe (slippery, sloped)
- Poor Housekeeping/Disorder
- Noise/Vibration
- Hazardous Materials/Chemicals Used
- Visibility Inadequate (dark, glare, obscured)
- Heavy Work Uncontrolled
- Production Pace Unsafe
- Emergency Systems/Provisions inadequate
- Temperature Extremes
- Poor Traffic Flow

Root causes of Accident (identify both personal factor(s) and management practice factor(s). Check as many as applicable.

Possible Personal Factors

- Insufficient Knowledge
- Insufficient Skill
- Insufficient Experience
- Insufficient Motivation
- Fatigue (mental or physical)
- Personal Issues
- Other:

Other/Comments:

Possible Management Practice Factors

- Leadership/Supervision/Enforcement
- Engineering/Design/Capacity/Containment
- Process/Work methods
- Maintenance/Inspection Program
- Staffing/Manpower/Hiring Practices
- Tools/Equipment Provided
- Hazardous Materials Alternatives/Controls
- Training/Development
- Hazard Identification/Evaluation

Preventative Measures to Consider. Check as many as applicable.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> General Enforcement Improvement | <input type="checkbox"/> Housekeeping/Disposal improvement | <input type="checkbox"/> Repair/Replace Equipment | <input type="checkbox"/> Formal Procedure |
| <input type="checkbox"/> Training or Re-Training of Employees | <input type="checkbox"/> Substitute Safer Alternative Material | <input type="checkbox"/> Congestion/Traffic Improvement | <input type="checkbox"/> Develp/Update |
| <input type="checkbox"/> Individual Corrective Counseling | <input type="checkbox"/> Guards/Safety Devices Improvement | <input type="checkbox"/> Supply/Purchasing Improvement | <input type="checkbox"/> Work Method Improvement |
| <input type="checkbox"/> PPE Improvement | <input type="checkbox"/> Engineering/Process Improvement | <input type="checkbox"/> Insp./Maintenance Improvement | <input type="checkbox"/> Workstation Re-Design |
| <input type="checkbox"/> Staffing/Hiring Stds./Development | <input type="checkbox"/> Visibility/Illumination Improvement | <input type="checkbox"/> Noise/Vibration Improvement | <input type="checkbox"/> Temperature Improvement |
| <input type="checkbox"/> Rotation of Employees | <input type="checkbox"/> Storage/Arrangement Improvement | <input type="checkbox"/> Emergency Systems/Provisions | <input type="checkbox"/> Ventilation Improvement |
| <input type="checkbox"/> Employee Awareness/Communication | <input type="checkbox"/> Provide Employee Incentive | <input type="checkbox"/> Safety Efforts Effectiveness | <input type="checkbox"/> Discontinue/Eliminate Task |
| <input type="checkbox"/> Job Re-Assignment of Employee(s) | <input type="checkbox"/> Remove Employee Disincentive | <input type="checkbox"/> Warning System Provided | <input type="checkbox"/> Remove/Eliminate Hazard |
| | | | <input type="checkbox"/> Conduct Hazard Analysis |

Other/Comments:

Specific Corrective Action(s) Taken

Person(s) Responsible

Target Date

Date Completed

Report Corrective Action(s) Updates Completed by: (Supervisor):

Date:

Manager:
Comments

Executive:
Comments

Safety Committee:
Comments