

For Human Resources Use Only		
HR Review:	Safety Log#:	
Dept. Org#:	OSHA Log#:	

EMPLOYEE ACCIDENT/INCIDENT ANALYSIS FORM

(Management should complete this form promptly with the impacted employee- Please <u>PRINT</u>)
When completing the form, please be as detailed as possible

Employee/Department Information (To be completed by Employee or Manager) Last Name First Name Home/Cell Phone **Work Phone Employee Department** Manager Department Work Phone Manager Time Employee began Work on Date of Incident FILE 801, IF BOXES BELOW ARE CHECKED **Medical Care Near Miss** 2. Accident/Incident Information First Aid Time Loss (To be completed by Employee or Manager) Fatal Date of Accident/Incident Time of Accident/Incident Date First Reported Time First Reported Accident/Incident Location: Describe Injury (Nature of Injury/Part of Body)/Incident: Describe Accident/Incident Fully (What happened and why?): Witness(es): Phone Number (s):

The purpose of this form is to assist Human Resources and the Safety Committee to identify safety issues on campus. It is very important that you be as detailed as possible when completing this form. Please submit additional pages if needed

Describe First Alay	'Medical Treatment	given(it any):					
Was a prescription	n given? YES	NO					
By Whom?				When?			
	If traatmo	at was sivon aw	ov fror	n the College, wh	oro was it givon)	
Name of Physician	/Health Care Profes			acility Name	iere was it given	:	
Name of Filysicial	i, rieaitii Care i roie.	SSIOTIAI	'	acinty Name			
Street			City			State	Zip
Was Employee tre	ated in an emergen	cv room?		Was employee	hospitalized ove	rnight?	
YES NO	ateu iii aii eiileigei	icy room:		YES NC	-	illigilt:	
	ction, use the descript anagement: <u>Do we</u> Hazard Recognition				mployee: Was th	e employe	
Corrective Action	Proper Resources	Job Safety Trainin		Mental/Physical Ability			roper Equipment U
Adequate Staffing	Safety Observation	Other:		Using Short Cuts	PPE Worn		Other:
Equipment: <u>Do we have?</u>				Environment: What about:			
Proper Tool Selection Visual Warnings	Tool Availability Guarding	Maintenance Other:		Physical conditions Biological/Chemical	Temperature Weather		oise errain/Lighting
risuai vvai illiigs	Guarung	Other.		Vibration/Ventilation	Ergonomics		Other:

5. Counter Measures/Best Practices (To be completed by <u>Manager</u>) Please complete area below with as much detail as possible

ounter Measure	Who?	By When?

6. Signatures

Completed by: (Please print)	Title:	
Employee Signature:	Date:	
Manager Signature:	Date:	

Revised: 5/22/14