

Date: ___/___/___



Accident/Incident Report/Investigation

Location Name: _____

Location Branch or Address: _____

Person Making This Report: _____

Near Miss Injury Occurred Property Damage

Type of Property Damage (if applicable): _____

Estimated Amount of Property Damage (\$):	<input type="checkbox"/>	0-500	<input type="checkbox"/>	5,001-10,000
	<input type="checkbox"/>	501-2,500	<input type="checkbox"/>	10,001-50,000
	<input type="checkbox"/>	2,501-5,000	<input type="checkbox"/>	>50,000

Accident Address (If different than location identified above):

Street/Intersection: _____

City: _____ State: _____ Zip: _____

Injured/Ill Employee or Person Causing Property Damage

Check if Employee

First Name: _____ Last Name: _____

Date of Birth: ___/___/___ Social Security #: _____

Supervisor: _____

Job Title:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Administrative | <input type="checkbox"/> Termite technician | <input type="checkbox"/> Construction |
| <input type="checkbox"/> Commercial Technician | <input type="checkbox"/> Residential Technician | <input type="checkbox"/> Electrician |

Experience:	Start Date	or	Years	Weeks
Job Title	___/___/___		_____	_____
At This Location	___/___/___		_____	_____
Total Industry	___/___/___		_____	_____

Drug Screen Given? Yes No

Employee Description of Accident: _____

Investigator Description of Accident: _____

PPE(s) required for Job; If not being used Properly:

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Respiratory Protection |
| <input type="checkbox"/> <input type="radio"/> Ear Plugs / Muffs | <input type="checkbox"/> <input type="radio"/> Fall support line |
| <input type="checkbox"/> <input type="radio"/> Fall Protection | <input type="checkbox"/> <input type="radio"/> Safety Glasses |
| <input type="checkbox"/> <input type="radio"/> Full Face Shields | <input type="checkbox"/> <input type="radio"/> Seat Belts |
| <input type="checkbox"/> <input type="radio"/> Gloves (chem. resistant) | <input type="checkbox"/> <input type="radio"/> Self Contained Breathing Apparatus |
| <input type="checkbox"/> <input type="radio"/> Hard Hats/Bump Cap | <input type="checkbox"/> <input type="radio"/> Steel Toed Boots/Shoes |
| <input type="checkbox"/> <input type="radio"/> Hot Gloves (electrical) | <input type="checkbox"/> <input type="radio"/> Non-slip Boots/Shoes |
| <input type="checkbox"/> <input type="radio"/> Hot Stick (electrical) | <input type="checkbox"/> <input type="radio"/> Other _____ |
| <input type="checkbox"/> <input type="radio"/> Locks for Lock-out/Tag-out | |

Date of Incident: ___/___/___ Time: ___:___ AM PM

Date Reported: ___/___/___ Time: ___:___ AM PM Time Shift Started: ___:___ AM PM

of Reportable Injuries Associated with this Accident: ___ (Complete new Accident Report for each injured employee)

Equipment Involved:

Type:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Vehicle | <input type="checkbox"/> Bait box | <input type="checkbox"/> Dispensing Unit |
| <input type="checkbox"/> Chemical | <input type="checkbox"/> Compressor | <input type="checkbox"/> Hoist |
| <input type="checkbox"/> Trap | <input type="checkbox"/> Blower | <input type="checkbox"/> Pump |
| <input type="checkbox"/> Sprayer | <input type="checkbox"/> Hose/Hose Reel | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ladder | <input type="checkbox"/> Power Tool | _____ |
| <input type="checkbox"/> Bait | <input type="checkbox"/> Fuel | _____ |
| <input type="checkbox"/> Hammer Drill | | |

Object Which Inflicted Injury/Illness or Property Damage: _____

Person in Control of Object/Equipment: _____

Accident Causes:

Actions:

- | | | |
|--|--|---|
| <input type="checkbox"/> N/A | <input type="checkbox"/> Improper Placement | <input type="checkbox"/> Servicing Equipment in Operation |
| <input type="checkbox"/> Employee Misconduct | <input type="checkbox"/> In a Hurry | <input type="checkbox"/> Under Influence of Drugs/Alcohol |
| <input type="checkbox"/> Failure to Secure | <input type="checkbox"/> Operating at Improper Speed | <input type="checkbox"/> Using Defective Equipment |
| <input type="checkbox"/> Failure to Use PPE Properly | <input type="checkbox"/> Operating Equipment | <input type="checkbox"/> Using Equipment Improperly |
| <input type="checkbox"/> Failure to Warn | <input type="checkbox"/> Removing Safety Devices | |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Safety Devices Inoperable | |
| <input type="checkbox"/> Improper Loading | <input type="checkbox"/> Safety Policy/Procedures | |
| <input type="checkbox"/> Improper Lifting | | |

Conditions:

- | | |
|---|--|
| <input type="checkbox"/> N/A | <input type="checkbox"/> Tools, Equipment or Materials |
| <input type="checkbox"/> Congested or Confined Space | <input type="checkbox"/> Ventilation |
| <input type="checkbox"/> Fire and Explosion Hazards | <input type="checkbox"/> Warning System |
| <input type="checkbox"/> Ground/Floor Hazard (Slippery/Icy) | |
| <input type="checkbox"/> Guards or Barriers | |
| <input type="checkbox"/> High/Low Temperature Exposures | |
| <input type="checkbox"/> Housekeeping | |
| <input type="checkbox"/> Illumination | |
| <input type="checkbox"/> PPE | |
| <input type="checkbox"/> Noise Exposures | |
| <input type="checkbox"/> Spillage | |

Personal Factors:

- N/A Physical Capability Knowledge Skill

Job Factors:

- N/A Equipment Wear and Tear Purchasing
 Engineering Leadership Tools/Equipment
 Equipment Abuse or Misuse Maintenance Work Standards/Rules

Decision Factors:

- N/A
- Body Mechanics**
 Alignment (back straight, knees bent, avoid twisting)
 Extension (feet flat, work within easy reach)
 Pace (maintain steady and controlled speed)
 Repetition (change often when doing repetitive tasks)
- Body Position**
 Confined space
 Eyes on path/work (keep eyes in direction of travel and task)
 Footing (stay on designated walkways/3point contact on stairs)
 Line of fire (position yourself out of the path of moving objects)
 Pinch points (keep body parts out of meeting surfaces)
- Housekeeping**
 Keep work area clean and free of litter
 Put all tools, equipment, and supplies where they belong
- Tool and Equipment Use**
 Make sure the tool/equipment is in good condition
 Select the proper tool/equipment for the job
 Use the tool/equipment properly
- PPE (selection, use, condition)**
 Body
 Ears
 Eyes/Face
 Feet
 Head
 Hands
 Lungs

Preliminary Severity: (check all that apply):

- First Aid Doctor Restricted Work Activity Lost Time OSHA Reportable
 Injury Resulted in Disability Injury Resulted in Death
 Immediately Reportable to Reg. Agency Date Reported: ___/___/___ Time: ___:___ AM PM

If Performing Job Other Than Normal Work Activity Explain: _____

Nature of Injury (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Avulsion | <input type="checkbox"/> Headache | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Broken Tooth | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Repeated Trauma |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sprain |
| <input type="checkbox"/> Contusion | <input type="checkbox"/> Laceration | <input type="checkbox"/> Strain |
| <input type="checkbox"/> Crush Injury | <input type="checkbox"/> Loss of Motion | <input type="checkbox"/> Upper Respiratory Infection |
| <input type="checkbox"/> Chemical Burn | <input type="checkbox"/> Loss of Strength | <input type="checkbox"/> Other Respiratory Diseases _____ |
| <input type="checkbox"/> Dermatitis/Skin Disorder | <input type="checkbox"/> Muscular Aches | <input type="checkbox"/> Other Occupational Disease _____ |
| <input type="checkbox"/> Dust/Lung Diseases | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Other Injury _____ |
| <input type="checkbox"/> Electrical Shock | <input type="checkbox"/> Pain | |
| <input type="checkbox"/> Foreign Body Eye | <input type="checkbox"/> Poisoning (insect/Snake Bites/Stings, Ivy) | |
| <input type="checkbox"/> Foreign Body | <input type="checkbox"/> Poisoning | |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Puncture Wound | |

Part of Body Injured (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Cheek <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Chest | <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Arm <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Ear <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Foot (Heel) <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Back (Upper) | <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Foot (Sole) <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Back (Mid) | <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Foot/toe 1 st (big) <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Back (Lower) | <input type="checkbox"/> Eye -Cornea <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Foot/toe 2 nd |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Eye - Retina <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Foot/toe 3 rd |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Face | <input type="checkbox"/> Foot/toe 4 th |

- Foot/toe 5th (pinky)
- Forehead
- Gall Bladder
- Groin
- Hand L R
- Hand (Back) L R
- Hand Palm L R
- Hand - Finger 1st (indx) L R
- Hand - Finger 2nd (mid) L R
- Hand - Finger 3rd (ring) L R
- Hand -Finger 4th (pinky) L R

- Hand - Thumb L R
- Head
- Heart
- Hip L R
- Hip Socket L R
- Jaw
- Knee L R
- Leg L R
- Liver
- Lung
- Mouth
- Neck
- Nose
- Pelvis
- Rectum

- Ribs L R
- Shoulder L R
- Spleen
- Stomach
- Teeth
- Thigh L R
- Tibia/Fibula L R
- Toe L R
- Tongue
- Top of Head
- Trachea
- Wrist L R
- Other _____

Type of Contact/Activity:

- N/A
- Bend
- Caught On
- Caught Between
- Caught In
- Fall on Same Level
- Fall to Below

- Forceful Repetitive Motion
- Kneel
- Lift
- Overexertion
- Reach
- Struck By
- Struck Against

- Slip
- Squat
- Sustained Difficult Posture
- Twist
- Work Overhead
- Other _____

Witness Statement:

Name: _____

Check if Employee

Social Security #: _____

Date of Statement: ___/___/___ Time: ___:___

AM PM

Involvement: By-stander/Observer

Directly Caused Accident

Indirectly Linked to Accident

Cause In Control of Equipment Other

Witness Statement:

Incident Disposition:

Employee Status: Full Duty Transitional Duty

Lost Time Permanent Accommodation Terminated

Corrective Actions:

Treating Physician's

Name: _____

Clinic Name: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone #: _____

Date Treated: ___/___/___ Physician's

Results/Recommendations: _____

Investigation Findings:



Incident Sketch