OFFICE OF RISK MANAGEMENT
UNIT OF RISK ANALYSIS AND LOSS PREVENTION
STATE EMPLOYEE INCIDENT/ACCIDENT INVESTIGATION FORM
Worker’s Compensation Claims—To Be Filled Out By Injured Worker’s Employer

(PLEASE TYPE OR PRINT)

1. AGENCY ________________________________________________________________

2. ACCIDENT DATE ________________________ 3. REPORTING DATE ________________________

4. EMPLOYEE NAME (LAST, FIRST) ________________________________ _______________________

5. JOB TITLE _________________________________________________________________

6. IMMEDIATE SUPERVISOR _________________________________________________

7. DESCRIBE IN DETAIL HOW INCIDENT/ACCIDENT OCCURRED (USE ADDITIONAL SHEET IF NECESSARY) ________________________________________________________________

8. PARISH WHERE OCCURRED ________________________________ ______

9. PARISH OF DOMICILE ________________________________ ______

10. WAS MEDICAL TREATMENT REQUIRED ________ Y ________ N

11. EXACT LOCATION WHERE EVENT OCCURRED ________________________________ ________________________________ ________________________________ __________

12. NAME (S) OF WITNESSES ________________________________________________

13. NAME OF PERSON COMPLETING THIS SECTION OF REPORT ________________________________ ________________________________ __________

14. SIGNATURE _____________________________________________________________ 15. DATE ________________________________ __________

KEEP COMPLETED FORMS ON FILE AT THE LOCATION WHERE INCIDENT/ACCIDENT OCCURRED

FORM DA 2000  REVISED 03/2006
MANAGEMENT SECTION

16. NAME OF PERSON COMPLETING THIS SECTION OF REPORT

__________________________________________________________

17. POSITION/TITLE

__________________________________________________________

18. IS THE PERSON COMPLETING REPORT TRAINED IN ACCIDENT INVESTIGATION ______ Y ______ N

19. WAS EQUIPMENT INVOLVED ______ Y ______ N (If no, skip to question 20)

A. TYPE OF EQUIPMENT

__________________________________________________________

B. IS THERE A JSA FOR EQUIPMENT ______ Y ______ N

C. DATE LAST JSO PERFORMED ________________

20. HAVE SIMILAR ACCIDENT/INCIDENTS OCCURRED ______ Y ______ N

21. DID INCIDENT INVOLVE SAME INDIVIDUAL ______ Y ______ N

22. SAME LOCATION ______ Y ______ N

23. WAS THE SCENE VISITED DURING THE INVESTIGATION ______ Y ______ N

A. DATE & TIME _____________________________

B. ARE PICTURES AVAILABLE ______ Y ______ N

C. IF NO, REASON FOR NOT VISITING _____________________________________________________________________________________________

ROOT CAUSE ANALYSIS

UNSAFE ACT (PRIMARY): □ Failure to comply with policies/procedures □ Failure to use appropriate equipment/technique □ Inattentiveness
□ Inadequate/lack of JSAs/standards □ Incomplete or no policies/procedures □ Inadequate training on policies/procedures □ Inadequate adherence of policies/procedures

Other (specify) ____________________________________________________________

Detailed explanation of checked box ____________________________________________________________________________________________

WHY WAS ACT COMMITTED:

UNSAFE CONDITION (PRIMARY): □ Inappropriate equip/tool □ Inadequate maintenance □ Inadequate training □ Wet surface
□ Worn/broken/defective building components □ Broken equipment □ Inadequate guard □ Electrical hazard □ Fire Hazard

Other (specify) ____________________________________________________________

Detailed explanation of checked box ____________________________________________________________________________________________

WHY DID CONDITION EXIST:

CONTRIBUTORY FACTORS (IF ANY):

IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

LONG RANGE ACTION TO BE TAKEN:

WHAT ADDITIONAL ASSISTANCE IS NEEDED TO PREVENT RECURRENCE:

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