

# Douglas Education Service District

## *Accident Investigation*

### SECTION 1: THIS SECTION TO BE FILLED OUT BY EMPLOYEE:

EMPLOYEE: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

DATE AND TIME OF INJURY: \_\_\_\_\_

ACCIDENT LOCATION: \_\_\_\_\_

ACCIDENT REPORTED TO: \_\_\_\_\_ DATE: \_\_\_\_\_

NATURE OF INJURY: \_\_\_\_\_

**DID INJURY REQUIRE MEDICAL ATTENTION?  YES  NO (IF YES, SAIF 801 FORM MUST BE FILLED OUT AS SOON AS POSSIBLE AT THE PERSONNEL OFFICE.)**

PARTS OF BODY AFFECTED \_\_\_\_\_

HAVE YOU INJURED THIS PART OF YOUR BODY PREVIOUSLY, OR IS THERE A PRE-EXISTING CONDITION THAT COULD AFFECT THIS INJURY?  YES  NO

IDENTIFY \_\_\_\_\_

#### CONTRIBUTING CONDITIONS:

- |   |  |
|---|--|
| <input type="checkbox"/> Defective Machinery                            | <input type="checkbox"/> Tool or equipment broke             |
| <input type="checkbox"/> Equipment inadequately guarded                 | <input type="checkbox"/> Proper tools/equipment unavailable  |
| <input type="checkbox"/> Floor, work surface, or walking surface unsafe | <input type="checkbox"/> Housekeeping                        |
| <input type="checkbox"/> Illumination                                   | <input type="checkbox"/> Clothing inappropriate for the task |
| <input type="checkbox"/> Other _____                                    |  |

#### WORK BEHAVIOR AT TIME OF INJURY: (Check all that apply.)

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Lifting             | <input type="checkbox"/> Carrying           | <input type="checkbox"/> Reaching    |
| <input type="checkbox"/> Pushing             | <input type="checkbox"/> Pulling            | <input type="checkbox"/> Bending     |
| <input type="checkbox"/> Running             | <input type="checkbox"/> Stepping           | <input type="checkbox"/> Jumping     |
| <input type="checkbox"/> Operating equipment | <input type="checkbox"/> Innocent bystander | <input type="checkbox"/> Other _____ |

Driving (what vehicle?) \_\_\_\_\_

Safety equipment in use?  Yes  No

If yes, was equipment:  adequate  inadequate  not available  improperly used

Safety rules:  adequate  inadequate  not enforced  improperly used

SPECIFICALLY WHAT WERE YOU DOING AT THE TIME OF THE ACCIDENT?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**SECTION 2: THIS SECTION TO BE FILLED OUT BY THE OFFICE MANAGER/SUPERVISOR:**

From your investigation, explain what the employee was doing just prior to and at the time of the accident. Use sequence of events and be specific.

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Have there been similar accidents in this same activity? If so, what has been done to prevent them?

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What does the employee think can be done to prevent recurrence?

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SUPERVISOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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**SECTION 3: REPORT OF ACCIDENT BY WITNESS(ES)**

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SIGNATURE OF WITNESS(ES) \_\_\_\_\_

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**SECTION 4: TO BE FILLED OUT BY HUMAN RESOURCES:**

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HR REPRESENTATIVE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

When completed, please send report to Human Resources. The accident will be discussed by District Safety Committee, with identity of accident victim being kept confidential. Thank you for your help.