Lane Community College

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 PRINT)
When completing the form, please be as detailed as possible

Employee/Department Information (To be completed by Employee or Manager)

Last Name	First Name	L#
Employee Department	Home/Cell Phone	Work Phone
Manager	Manager Department	Work Phone
Time Employee began Work on Date of Incident		

2. Accident/Incident Information

(To be completed by Employee or Manager)

☐ Near Miss
☐ First Aid

FILE 801, IF BOXES BELOW ARE CHECKED
☐ Medical Care
☐ Time Loss
☐ 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

3. First Aid/Medical Treatment Given (To be completed by Employee or Manager)

Describe First Aid/Medical Treatment given(if any):			
Was a prescription given? ☐ YES ☐ NO			
By Whom?	When?		
If treatment was given away from the College, where was it given?			
Name of Physician/Health Care Professional	Facility Name		
Street	City	State	Zip
Was Employee treated in an emergency room? ☐ YES ☐ NO	Was employee hospitalized overnight? ☐ YES ☐ NO		

4. Factors (To be completed by **Manager**) Please complete each area below with as much detail as possible. When completing each section, use the descriptors to help identify factors that may have contributed to the accident/incident

Management: **Do we have?**			**Employee: Was the employee?**		
Policy Enforcement	Hazard Recognition	Supervisor Training	Following Procedure	Trained	Previous Injury
Corrective Action	Proper Resources	Job Safety Training	Mental/Physical Ability	Safety Attitude	Proper Equipment Use
Adequate Staffing	Safety Observation	☐ Other:	Using Short Cuts	PPE Worn	☐ Other:
Equipment: Do we have?			**Environment: What about:**		
Proper Tool Selection	Tool Availability	Maintenance	Physical conditions	Temperature	Noise
Visual Warnings	Guarding	☐ Other:	Biological/Chemical	Weather	Terrain/Lighting
			Vibration/Ventilation	Ergonomics	☐Other:

Additional Factors: ☐ Faulty Equipment ☐ Non-Employee ☐ Prior Injury ☐ Late Reporting ☐ Off-the-Job Injury

5. Counter Measures/Best Practices (To be completed by **Manager**)

Please complete area below with as much detail as possible.

How do we correct areas identified as factors in causing the incident/accident?
Who will make changes and when will the changes be completed? Use other side of form if needed. Consider immediate and long-term corrective actions.

Counter Measure	**Who?**	**By When?**

Work Order #: _____ *(If counter measure includes a work order, please indicate work order #)*

6. Signatures

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

Send to Human Resources when Completed

Revised: 5/22/14