

- Near-Miss
- First Aid
- FILE 801, IF BOXES BELOW ARE CHECKED**
- Medical Care
- Time Loss
- Fatal

Log # \_\_\_\_\_

Lane Community College

# ACCIDENT/INCIDENT ANALYSIS

Immediate supervisor should complete this form promptly with worker.

## SYSTEM CHALLENGES

### Management:

#### Do we have?

- Policy Enforcement
- Hazard Recognition
- Accountability
- Supervisor Training
- Corrective Action
- Production Priority
- Proper Resources
- Job Safety Training
- Hiring Practices
- Maintenance
- Adequate Staffing
- Safety Observations

### Employee:

#### Was the employee?

- Following Procedure
- Training
- Previous Injury
- Mental Ability
- Physical Capacity
- Equipment Use
- Short Cuts
- PPE Worn
- Safety Attitude

### Equipment:

#### Do we have?

- Proper Tool
- Selection
- Tool Availability
- Maintenance
- Visual Warnings
- Guarding

### Environment:

#### What about:

- Plant Layout
- Temperature
- Noise
- Radiation
- Weather
- Terrain, Lighting
- Vibration, Ventilation
- Ergonomics
- Housekeeping
- Biological, Chemical

### Additional Factors

- Faulty Equipment
- Non-Employee
- Prior Injury
- Late Reporting
- Off-the-Job Injury

(Explain any checked boxes on separate sheet)

1. Employee: \_\_\_\_\_ Dept: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Date/Time of Accident: \_\_\_\_\_ Date/Time First Reported: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Dept: \_\_\_\_\_ Phone: \_\_\_\_\_

3. Accident Location: \_\_\_\_\_

4. Describe Injury (Nature of Injury/Part of Body): \_\_\_\_\_

5. Describe Accident Fully (what happened and why?): \_\_\_\_\_

6. Describe First Aid/Medical Treatment given: \_\_\_\_\_

By Whom? \_\_\_\_\_ When? \_\_\_\_\_

7. Identify factors which contributed to or caused the accident (refer to list on left side of page): \_\_\_\_\_

<b>Management:</b>	<b>Employee:</b>	
<b>Equipment:</b>	<b>Environment:</b>	
<b>Counter Measures/Best Practice:</b> How do we correct areas identified in the MEEE area above? Who will make changes and when will the changes be completed? Use other side if needed. Consider immediate and long-term corrective actions.		
	<b>Who?</b>	<b>By When?</b>

8. List witnesses & phone numbers: \_\_\_\_\_ Phone: \_\_\_\_\_

9. Treating physician, if known: \_\_\_\_\_ Phone: \_\_\_\_\_

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Copies to: Human Resources  
Director for Health & Safety