SIPE ACCIDENT INVESTIGATION REPORT

Print Form

The injured employee's **supervisor** shall complete the Accident Investigation Report immediately following an illness or injury

Provide as much detail as possible. PLEASE PRINT OR TYPE

GENERAL DATA

DATE OF REPORT

SCHOOL DISTRICT	SCHOOL SITE	SITE PHONE
Please Select District		
EMPLOYEE NAME (PRINT)	DATE OF BIRTH (MM/DD/YY)	GENDER ☐ MALE ☐ FEMALE
OCCUPATION (REGULAR JOB TITLE)	DATE EMPLOYER WAS NOTIFIED OF INCIDENT	DATE THE EMPLOYEE WAS PROVIDED WITH DWC-1 FORM

EMPLOYEE USUALLY WORKS

____ HRS/DAY ____ DAY/WEEK ____ TOTAL HRS/WEEK

EMPLOYMENT STATUS (CHECK APPLICABLE STATUS AT TIME OF INJURY)

☐ FULL TIME ☐ PART TIME ☐ TEMPORARY ☐ SEASONAL

DATE OF INCIDENT	TIME OF INCIDENT	TIME EMPLOYEE BEGAN WORK	IF EMPLOYEE DIED, DATE OF DEATH
	____ : ____ AM ____ : ____ PM	____ : ____ AM ____ : ____ PM	

UNABLE TO WORK AT LEAST ONE FULL DAY **AFTER** DATE OF INJURY?	LAST DAY WORKED	DATE RETURNED TO WORK	IF STILL OFF WORK, EXPECTED RETURN DATE
☐ YES ☐ NO			

IF THE PHYSICIAN IS **NOT** FROM THE RECOMMENDED MEDICAL CLINICS FOR WORKERS' COMPENSATION INJURIES, DOES THE EMPLOYEE HAVE A FORM ON FILE TO SEE A PERSONAL PHYSICIAN?

☐ YES ☐ NO

WHO TRANSPORTED THE EMPLOYEE TO THE DOCTOR?	DID THE INJURY OCCUR ON SCHOOL DISTRICT PROPERTY?
	☐ YES ☐ NO IF NO, LOCATION OF INCIDENT _____
WAS THE INCIDENT SCENE VISITED AS PART OF THIS INVESTIGATION? IF YES, BY WHOM?	WERE PHOTOS TAKEN AT THE SITE OF THE INCIDENT? *IF YES, INCLUDE WITH REPORT*
☐ YES ☐ NO _____	☐ YES ☐ NO

NAME OF SUPERVISOR

INJURY/ILLNESS DATA

PLEASE CHECK ALL THAT APPLY

CLASS OF INJURY

☐ FATALITY ☐ LOST WORKDAY ☐ RESTRICTED WORK ☐ MEDICAL ONLY ☐ FIRST AID ☐ FOR RECORD ONLY

NATURE OF INJURY

☐ ABRASIONS ☐ AMPUTATION ☐ BITES/STINGS ☐ BURNS ☐ CONCUSSION ☐ CONTUSION ☐ CRUSHING ☐ DISLOCATION ☐ FOREIGN BODY ☐ FRACTURE ☐ HEARING LOSS ☐ HEAT EXHAUSTION/ STROKE ☐ HERNIA ☐ INFECTIOUS DISEASE ☐ LACERATION ☐ MENTAL DISORDER ☐ POISONING ☐ PUNCTURE ☐ RASH ☐ REPETITIVE MOTION ☐ RESPIRATORY ☐ STRAIN/SPRAIN ☐ OTHER _____

PART OF BODY AFFECTED

☐ ABDOMEN ☐ ANKLE ☐ ARM ☐ BACK ☐ CHEST ☐ ELBOW ☐ EYES ☐ FINGER ☐ FOOT ☐ HAND ☐ HEAD/FACE ☐ HIP ☐ KNEE ☐ LEG ☐ NECK ☐ SHOULDER ☐ TEETH ☐ TOE ☐ WRIST ☐ OTHER _____

TYPE OF ACCIDENT

☐ ASSAULT OR VIOLENCE ☐ BODILY REACTION ☐ CAUGHT IN, UNDER OR BETWEEN ☐ EXPOSURE ☐ FALL FROM ELEVATION ☐ FALL TO FOOT LEVEL ☐ FIRE OR EXPLOSION ☐ MOTOR VEHICLE ☐ OVEREXERTION ☐ SLIP ☐ STRUCK AGAINST ☐ STRUCK BY ☐ TRIP ☐ OTHER _____

SOURCE OF INJURY

☐ AIR PRESSURE ☐ ANIMAL ☐ CHEMICAL ☐ ELECTRICAL ☐ ENVIRONMENTAL ☐ EXTREME TEMPERATURE ☐ HAND TOOL ☐ HUMAN ☐ INFECTIOUS AGENT ☐ INSECT ☐ LADDER/SCAFFOLD ☐ LIFTING/CARRYING ☐ MACHINERY ☐ NEEDLESTICK ☐ NOISE ☐ PARTICULATES ☐ PARTS & MATERIALS ☐ POWER TOOL ☐ PUSHING OR PULLING ☐ STAIRS ☐ VEGETATION ☐ VEHICLE ☐ WORKING SURFACE ☐ OTHER _____

UNSAFE CONDITIONS

☐ DEFECTIVE TOOLS/EQUIPMENT ☐ ENVIRONMENTAL HAZARD ☐ EXCESSIVE NOISE ☐ HAZARDOUS WORKSURFACE ☐ IMPROPER DESIGN ☐ IMPROPER USE OF TOOLS ☐ IMPROPER WORKSPACE ☐ INADEQUATE GUARDING ☐ INADEQUATE ILLUMINATION ☐ INADEQUATE VENTILATION ☐ LACK OF MAINTENANCE ☐ LACK OF WARNING SIGNS ☐ POOR DESIGN ☐ POOR HOUSEKEEPING ☐ UNPREDICTABLE ACTIONS ☐ UNSUITABLE MATERIAL ☐ OTHER _____

UNSAFE ACT

☐ CREATING ADDITIONAL HAZARDS ☐ FAILURE TO FOLLOW INSTRUCTIONS OR PROCEDURES ☐ FAILURE TO IDENTIFY A HAZARD ☐ FAILURE TO INSPECT EQUIPMENT ☐ FAILURE TO USE PPE ☐ HORSEPLAY ☐ IGNORED KNOWN HAZARD ☐ IMPROPER LIFT/CARRY ☐ INATTENTION TO FOOTING OR SURROUNDINGS ☐ JUMP FROM ELEVATION ☐ MISUSE OF TOOLS/EQUIPMENT ☐ REMOVING SAFETY DEVICES ☐ UNAUTHORIZED OPERATION ☐ UNSAFE BODILY POSITION ☐ UNSAFE SPEED ☐ USING UNSAFE EQUIPMENT ☐ WEARING IMPROPER ATTIRE ☐ NO UNSAFE ACT ☐ OTHER _____

SUPERVISORY RESPONSIBILITY

- ☐ FAILURE TO ENFORCE SAFETY RULES
- ☐ FAILURE TO PROVIDE PROPER PPE
- ☐ FAILURE TO PROVIDE PROPER TOOLS
- ☐ FAILURE TO PROVIDE PROPER TOOLS
- ☐ IMPROPER MAINTENANCE
- ☐ INADEQUATE INSPECTIONS
- ☐ LACK OF EQUIPMENT
- ☐ LACK OF OVERSIGHT/SUPERVISION
- ☐ LACK OF PLANNING
- ☐ LACK OF PROCEDURES
- ☐ POOR COMMUNICATION
- ☐ WRONG PERSONNEL ASSIGNED
- ☐ NOT APPLICABLE
- ☐ OTHER _____

DESCRIPTION OF ACCIDENT

TO BE COMPLETED **WITH** INJURED EMPLOYEE (*ATTACH A SEPARATE SHEET IF NECESSARY)*

Describe in detail what happened:

Provide exact location where accident occurred and be specific.:

Describe how the injury occurred:

Describe the activity, sequence of events, and conditions that led to this accident:

Could the accident have been prevented? ☐ YES ☐ NO Please explain.

Names and statements from witnesses:
(ATTACH STATEMENT ON A SEPARATE SHEET)

Name: _____ Name: _____

Signature: _____ Signature: _____

CORRECTIVE ACTION

What corrective action will be taken to prevent recurrence?

Who is responsible for corrective action and what is the expected completion date?

Name: _____ Date: _____ Name: _____ Date: _____

REQUIRED SIGNATURES

INVESTIGATED BY: _____ DATE: _____

REVIEWED BY DIRECTOR/SITE ADMINISTRATOR: _____ DATE: _____

REVIEWED BY DISTRICT SAFETY COORDINATOR _____ DATE: _____

PRINT THE NAME OF THE PERSON FILLING OUT THIS REPORT: _____ DATE: _____

Print Form