

SIPE ACCIDENT INVESTIGATION REPORT

Save

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****PLEASE FAX, EMAIL, OR MAIL A COPY OF THIS REPORT TO SIPE WITHIN 7 BUSINESS DAYS****GENERAL DATA**

DATE OF REPORT _____

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SCHOOL DISTRICT <u>Choose a District</u>		SCHOOL SITE	SITE PHONE
EMPLOYEE NAME (PRINT)		YEAR OF BIRTH (YYYY)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> 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) <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> SEASONAL	
DATE OF INCIDENT	TIME OF INCIDENT ____ : ____ AM ____ : ____ PM	TIME EMPLOYEE BEGAN WORK ____ : ____ AM ____ : ____ PM	IF EMPLOYEE DIED, DATE OF DEATH
UNABLE TO WORK AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST DAY WORKED	DATE RETURNED TO WORK	IF STILL OFF WORK, EXPECTED RETURN DATE
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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
WHO TRANSPORTED THE EMPLOYEE TO THE DOCTOR?		DID THE INJURY OCCUR ON SCHOOL DISTRICT PROPERTY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, LOCATION OF INCIDENT _____	
WAS THE INCIDENT SCENE VISITED AS PART OF THIS INVESTIGATION? IF YES, BY WHOM? <input type="checkbox"/> YES <input type="checkbox"/> NO _____		WERE PHOTOS TAKEN AT THE SITE OF THE INCIDENT? IF YES, INCLUDE WITH REPORT <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SUPERVISOR			

INJURY/ILLNESS DATA**PLEASE CHECK ALL THAT APPLY**

CLASS OF INJURY <input type="checkbox"/> FATALITY <input type="checkbox"/> LOST WORKDAY <input type="checkbox"/> RESTRICTED WORK <input type="checkbox"/> MEDICAL ONLY <input type="checkbox"/> FIRST AID <input type="checkbox"/> FOR RECORD ONLY			
NATURE OF INJURY <input type="checkbox"/> ABRASIONS <input type="checkbox"/> BURNS <input type="checkbox"/> CRUSHING <input type="checkbox"/> FRACTURE <input type="checkbox"/> HERNIA <input type="checkbox"/> MENTAL DISORDER <input type="checkbox"/> RASH <input type="checkbox"/> STRAIN/SPRAIN <input type="checkbox"/> AMPUTATION <input type="checkbox"/> CONCUSSION <input type="checkbox"/> DISLOCATION <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> INFECTIOUS DISEASE <input type="checkbox"/> POISONING <input type="checkbox"/> REPETITIVE MOTION <input type="checkbox"/> OTHER <input type="checkbox"/> BITES/STINGS <input type="checkbox"/> CONTUSION <input type="checkbox"/> FOREIGN BODY <input type="checkbox"/> HEAT EXHAUSTION/STROKE <input type="checkbox"/> LACERATION <input type="checkbox"/> PUNCTURE <input type="checkbox"/> RESPIRATORY			
PART OF BODY AFFECTED <input type="checkbox"/> ABDOMEN <input type="checkbox"/> ARM <input type="checkbox"/> CHEST <input type="checkbox"/> EYES <input type="checkbox"/> FOOT <input type="checkbox"/> HEAD <input type="checkbox"/> KNEE <input type="checkbox"/> NECK <input type="checkbox"/> TEETH <input type="checkbox"/> WRIST <input type="checkbox"/> RIGHT <input type="checkbox"/> ANKLE <input type="checkbox"/> BACK <input type="checkbox"/> ELBOW <input type="checkbox"/> FINGER <input type="checkbox"/> HAND <input type="checkbox"/> HIP <input type="checkbox"/> LEG <input type="checkbox"/> SHOULDER <input type="checkbox"/> TOE <input type="checkbox"/> FACE <input type="checkbox"/> LEFT		SIDE OF BODY AFFECTED	
TYPE OF ACCIDENT <input type="checkbox"/> ASSAULT OR VIOLENCE <input type="checkbox"/> CAUGHT IN, UNDER OR BETWEEN <input type="checkbox"/> FALL FROM ELEVATION <input type="checkbox"/> FIRE OR EXPLOSION <input type="checkbox"/> OVEREXERTION <input type="checkbox"/> STRUCK AGAINST <input type="checkbox"/> TRIP <input type="checkbox"/> BODILY REACTION <input type="checkbox"/> EXPOSURE <input type="checkbox"/> FALL TO FOOT LEVEL <input type="checkbox"/> MOTOR VEHICLE <input type="checkbox"/> SLIP <input type="checkbox"/> STRUCK BY <input type="checkbox"/> OTHER _____			
SOURCE OF INJURY <input type="checkbox"/> AIR PRESSURE <input type="checkbox"/> ELECTRICAL <input type="checkbox"/> HAND TOOL <input type="checkbox"/> INSECT <input type="checkbox"/> MACHINERY <input type="checkbox"/> PARTICULATES <input type="checkbox"/> PUSHING OR PULLING <input type="checkbox"/> VEHICLE <input type="checkbox"/> ANIMAL <input type="checkbox"/> ENVIRONMENTAL <input type="checkbox"/> HUMAN <input type="checkbox"/> LADDER/SCAFFOLD <input type="checkbox"/> NEEDLESTICK <input type="checkbox"/> PARTS & MATERIALS <input type="checkbox"/> STAIRS <input type="checkbox"/> WORKING SURFACE <input type="checkbox"/> CHEMICAL <input type="checkbox"/> EXTREME TEMPERATURE <input type="checkbox"/> INFECTIOUS AGENT <input type="checkbox"/> LIFTING/CARRYING <input type="checkbox"/> NOISE <input type="checkbox"/> POWER TOOL <input type="checkbox"/> VEGETATION <input type="checkbox"/> OTHER _____			
UNSAFE CONDITIONS <input type="checkbox"/> DEFECTIVE TOOLS/EQUIPMENT <input type="checkbox"/> HAZARDOUS WORKSURFACE <input type="checkbox"/> IMPROPER WORKSPACE <input type="checkbox"/> INADEQUATE VENTILATION <input type="checkbox"/> POOR DESIGN <input type="checkbox"/> UNSUITABLE MATERIAL <input type="checkbox"/> ENVIRONMENTAL HAZARD <input type="checkbox"/> IMPROPER DESIGN <input type="checkbox"/> INADEQUATE GUARDING <input type="checkbox"/> LACK OF MAINTENANCE <input type="checkbox"/> POOR HOUSEKEEPING <input type="checkbox"/> OTHER <input type="checkbox"/> EXCESSIVE NOISE <input type="checkbox"/> IMPROPER USE OF TOOLS <input type="checkbox"/> INADEQUATE ILLUMINATION <input type="checkbox"/> LACK OF WARNING SIGNS <input type="checkbox"/> UNPREDICTABLE ACTIONS			
UNSAFE ACT <input type="checkbox"/> CREATING ADDITIONAL HAZARDS <input type="checkbox"/> FAILURE TO INSPECT EQUIPMENT <input type="checkbox"/> IGNORED KNOWN HAZARD <input type="checkbox"/> JUMP FROM ELEVATION <input type="checkbox"/> UNAUTHORIZED OPERATION <input type="checkbox"/> USING UNSAFE EQUIPMENT <input type="checkbox"/> FAILURE TO FOLLOW INSTRUCTIONS OR PROCEDURES <input type="checkbox"/> FAILURE TO USE PPE <input type="checkbox"/> IMPROPER LIFT/CARRY <input type="checkbox"/> MISUSE OF TOOLS/EQUIPMENT <input type="checkbox"/> UNSAFE BODILY POSITION <input type="checkbox"/> WEARING IMPROPER ATTIRE <input type="checkbox"/> FAILURE TO IDENTIFY A HAZARD <input type="checkbox"/> HORSEPLAY <input type="checkbox"/> INATTENTION TO FOOTING OR SURROUNDINGS <input type="checkbox"/> REMOVING SAFETY DEVICES <input type="checkbox"/> UNSAFE SPEED <input type="checkbox"/> NO UNSAFE ACT <input type="checkbox"/> OTHER _____			

Fax: (805) 460-0286 Email: SIPE@slosipe.org 7455 Morro Road, Atascadero, CA 93422
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Appendix G

SUPERVISORY RESPONSIBILITY

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> FAILURE TO ENFORCE SAFETY RULES | <input type="checkbox"/> LACK OF EQUIPMENT | <input type="checkbox"/> LACK OF PROCEDURES | <input type="checkbox"/> IMPROPER MAINTENANCE | <input type="checkbox"/> NOT APPLICABLE |
| <input type="checkbox"/> FAILURE TO PROVIDE PROPER PPE | <input type="checkbox"/> LACK OF OVERSIGHT/SUPERVISION | <input type="checkbox"/> POOR COMMUNICATION | <input type="checkbox"/> INADEQUATE INSPECTIONS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> FAILURE TO PROVIDE PROPER TOOLS | <input type="checkbox"/> LACK OF PLANNING | <input type="checkbox"/> WRONG PERSONNEL ASSIGNED | | |

DESCRIPTION OF ACCIDENTTO 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 Please explain:
☐ NO

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: _____