

Staff/Volunteer Injury - Incident Analysis Report

Ashland School District 885 Siskiyou Blvd., Ashland, OR 97520

541-482-2811

(Fact-finding Not Fault-finding)

EMPLOYEE
DEPARTMENT
ACCIDENT LOCATION
DATE OF INJURY
ACCIDENT REPORTED TO
DATE ACCIDENT REPORTED

JOB TITLE
DATE OF HIRE
SUPERVISOR
TIME OF INJURY
HOW REPORTED
TIME REPORTED 801 FILED? Y () N ()

<u>PART(S) OF BODY AFFECTED</u>		
<u>Head/Neck</u>	<u>Left Side</u>	<u>Right Side</u>
() Scalp	()	()
() Neck	()	()
() Ears	()	()
() Eyes	()	()
() Mouth	()	()
() Teeth	()	()
() Face	()	()
<u>Upper Extremities</u>	<u>Left Side</u>	<u>Right Side</u>
() Shoulder	()	()
() Upper Arm	()	()
() Elbow	()	()
() Forearm	()	()
() Wrist	()	()
() Hand	()	()
() Fingers	()	()
<u>Lower Extremities</u>	<u>Left Side</u>	<u>Right Side</u>
() Thigh	()	()
() Lower Leg	()	()
() Knee	()	()
() Ankle	()	()
() Foot/Toes	()	()
<u>Trunk</u>	<u>Left Side</u>	<u>Right Side</u>
() Lower Back	()	()
() Upper Back	()	()
() Chest	()	()
() Abdomen	()	()
() Hip	()	()
() Groin	()	()

<u>NATURE OF INJURY</u>	
() Cut	() Foreign Body in Eye or Sliver
() Scrape	() Burn
() Bruise	() Electric Shock
() Skin Rash	() Pain in Body Part Identified at Left
() Difficulty Breathing	() Jammed Finger or Toe
() Numbness	() Inflammation
Has individual injured this part(s) of the body previously or is there any pre-existing condition that could affect injury? Y () N ()	
Identify:	

<u>CONTRIBUTING FACTORS</u>
() Machinery Defect (Save defective parts & pieces)
() Tool or Equipment Broke (Save broken parts & pieces)
() Equipment Guarding
() Proper Tools/Equipment Not Available
() Floor, Work Surface, or Walking Surface
() Housekeeping
() Lighting
() Clothing or Jewelry

<u>WORK BEHAVIOR AT TIME OF INJURY</u>	
<i>(Please check all items that pertain)</i>	
() Lifting	
() Carrying	
() Reaching	
() Pushing	
() Pulling	
() Bending or Twisting (circle correct item)	
() Running	
() Stepping (walking or moving from one level to another)	
() Typing	
() Other Repetitive Motion Tasks	
() Jumping	
() Driving (If so, what vehicle?)	
() Operating Equipment	
() Innocent Bystander	
() Other _____	

Employee may have a copy of the signed form.

SAFETY EQUIPMENT IN USE

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Gloves | <input type="checkbox"/> Respirator |
| <input type="checkbox"/> Face Shield | <input type="checkbox"/> Seat Belt |
| <input type="checkbox"/> Apron | <input type="checkbox"/> Safety Glasses/Goggles |

EXPLAIN WHAT EMPLOYEE WAS DOING JUST PRIOR TO & AT THE TIME OF THE ACCIDENT
(USE SEQUENCE OF EVENTS. PLEASE BE SPECIFIC)

HOW LONG HAS EMPLOYEE WORKED AT THIS SPECIFIC JOB?

HAVE THERE BEEN NEAR-MISSES OR MINOR ACCIDENTS IN THIS SAME ACTIVITY? HAS ANY ACTION
BEEN TAKEN?

WHAT DOES EMPLOYEE THINK CAN BE DONE TO PREVENT RECURRENCE?

SUPERVISOR'S COMMENTS ON CORRECTIVE ACTION:

PROVIDE WITNESS INFORMATION ON SEPARATE PAPER

Injured Employee's Signature	_____	DATE
Supervisor's Signature	_____	DATE
Manager's Signature	_____	DATE

SAFETY COMMITTEE EVALUATION

CORRECTIVE ACTION NEEDED

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Improve Design | <input type="checkbox"/> Improve Housekeeping | <input type="checkbox"/> Safety Devices | <input type="checkbox"/> Pers. Prot. Equipment |
| <input type="checkbox"/> Repair or Replace Equip. | <input type="checkbox"/> More Direct Supervision | <input type="checkbox"/> Job Safety Analysis | <input type="checkbox"/> Maintain Clean Work Area |
| <input type="checkbox"/> Training | <input type="checkbox"/> Establish Rule/Procedures | <input type="checkbox"/> Discipline (Rule Enforcement) | |

SAFETY EQUIPMENT

- Availability of Equipment
- Proper Equipment
- Not in Use
- Training Required

SAFETY RULES

- Adequate
- Inadequate
- Not Understood
- Enforcement Issue

RECOMMENDATION(S):