

INCIDENT ANALYSIS FORM

- Incident analysis helps you in reducing or preventing future occupational injuries and illnesses.
- This form requests all the information that the DWC says you must record for each on-the-job injury, fatality, and occupational disease. Employers must keep injury records for five years after the last day of the year in which the injury occurred.

This is an **Injury** **Disease** **Fatality** **Near-miss**

TODAY'S DATE _____

DATE REPORTED _____

COMPANY _____

DEPARTMENT _____

SUPERVISOR _____

PHONE NO. _____

1. Name of Person Involved		2. Sex	3. Social Security Number		4. DOB	5. Date of Incident
6. Home Address _____ _____ Phone ()		7. Time and Day of Incident _____ a.m.; _____ p.m.; day of week _____		8. Specific Location of Incident Was it on employer's premises? <input type="checkbox"/> yes <input type="checkbox"/> no		
		9. Employee's Occupation		10. Job Task at Time of Incident		
13. Name and Address of Treating Physician _____ _____ Phone ()		11. Length of Service _____ Years; _____ Months		12. Employee was Working <input type="checkbox"/> Alone <input type="checkbox"/> With Fellow Workers <input type="checkbox"/> Other		
		14. Employment Category <input type="checkbox"/> Regular, full-time <input type="checkbox"/> Temporary <input type="checkbox"/> Regular, part-time <input type="checkbox"/> Non-employee <input type="checkbox"/> Seasonal		15. Experience in Occupation at Time of Incident <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1 to 5 month <input type="checkbox"/> 6 months to 1 year <input type="checkbox"/> 1 to less than 5 years <input type="checkbox"/> 5 or more years		
16. Name and Address of Hospital _____ _____		17. Phase of Employee's Workday at Time of Injury <input type="checkbox"/> During break period <input type="checkbox"/> During meal period <input type="checkbox"/> Working overtime <input type="checkbox"/> Entering or leaving the building <input type="checkbox"/> Performing work duties <input type="checkbox"/> Other (explain below)				
		18. Name of employee's immediate Supervisor at time of incident Incident? _____ Witnessed <input type="checkbox"/> Yes <input type="checkbox"/> No				
19. Employee's Wage (pay per Hour)		20. Other Witnesses _____				
21. Voluntary benefits paid by the employer, if any						

22. PART of BODY INJURED or AFFECTED

- Skull, Scalp Jaw Abdomen Shoulder Wrist Knee Foot
- Eye Neck Back Upper Arm Hand Thigh Toe
- Nose Spine Pelvis Elbow Finger Lower Leg Ankle
- Mouth Chest Other Body Part Forearm Hip Other _____

23. NATURE of INJURY or ILLNESS

- Puncture Bruise, Contusion Skin Disorder Amputation Muscle Sprain Cumulative Trauma Disorder
- Laceration Dislocation Burn Insect/Animal Bite Muscle Strain Irritation
- Fracture Abrasion Respiratory Foreign Body Hernia Infection
- Heat/Cold Stress Hearing Loss Chemical Exp. Other _____

24. DISPOSITION

- Days away from work # _____
- Restricted work days # _____
- Date returned to work # _____
- Sent to: Doctor Hospital

25. DIAGNOSIS

26. SEVERITY

- First Aid Medical Treatment
- Lost Work Days Fatality
- Other: Specify _____

27. WHAT CONDITION of TOOLS, EQUIPMENT, or WORK AREA CONTRIBUTED TO INCIDENT? Not Applicable

- Close Clearance/Congestion Floors/Work Surfaces Inadequate Housekeeping Defective Tools/Equipment/Vehicle
- Hazardous Placement Inadequate Ventilation Equipment Failure Illumination
- Inadequate Warning System Equipment/Workstation Design Inadequate Guards/Barrier Inadequate/Improper P.P.E.

28. WHAT CAUSED or INFLUENCED SUBSTANDARD CONDITIONS? No Substandard Conditions

- Abuse or Misuse Inadequate Supervision Inadequate Purchasing Inadequate Engineering
- Inadequate Maintenance Inadequate Tools/Equip..Mat. Improper Work Surfaces Wear and Tear
- Lack of Knowledge/Training Improper Motivation Inadequate Capacity Lack of Skill

29. WHAT ACTION or INACTION CONTRIBUTED to the INCIDENT? Not Applicable

- Failure to Make Secure Under Influence Drugs/Alcohol Failure to Warn/Signal Inadequate/Improper P. P. E. Use
- Nullified Safety/Control Devices Used Defective Equipment Horseplay/Distractive Active Operating at Improper Speed
- Used Equipment Improperly Improper Lifting Operating Procedure Deviation
- Running/Rushing/Acting in Haste Improper Loading Unauthorized Actions Used Wrong Tool/Equipment
- Improper Technique Improper Position Servicing/Operating Equipment
- Other _____

30. PROBABLE RECURRENCE

- Frequent Occasional Rare

31. LOSS SEVERITY POTENTIAL

- Major Serious Minor

32. PREVENTIVE MEASURES: (What corrective actions have been taken or are planned to prevent a recurrence?)

- Improve Enforcement Improve Clean-up Procedures Repair/Replace Equipment Corrective Counseling
- Improve Storage/Arrangement Rotation of Employee Eliminate Congestion Improve/Change Work Method
- Identify/Improve P. P. E Install/Revise Guards/Devices Task Analysis to Be Completed
- Task Analysis/Procedure Revision Improve Design/Construction Job Reassignment of Employees
- Use Other Materials/Supplies Improve Illumination Mandatory Pre-Job Instructions
- Improve Ventilation Reinstruction of Employees Other _____

33. EMPLOYEE'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) Comments sheet

34. SUPERVISOR'S DESCRIPTION of INCIDENT (Attach sheet for additional comments) Comments sheet

35. SPECIFIC CORRECTIVE ACTIONS or PREVENTIVE MEASURES TAKEN

Corrective Action Taken	Person Responsible	Target Date	Date Completed

Supervisor's Signature _____

Date _____