Central Point School District 6

SUPERVISOR'S ACCIDENT/ILLNESS ANALYSIS

STAFF INJURY

(Fact-finding Not Fault-finding)

Employee:

Job Title:

School/Building:

Date Of Injury:

Time Of Injury:

Accident Location:

Supervisor:

Accident Reported To:

Date Accident Reported:

How Reported:

801 Filed? Yes ( ) No ( )

PART(S) OF BODY AFFECTED

Head/Neck	Left Side	Right Side
( ) Scalp	( )	( )
( ) Neck	( )	( )
( ) Ears	( )	( )
( ) Eyes	( )	( )
( ) Mouth	( )	( )
( ) Teeth	( )	( )
( ) Face	( )	( )

Upper Extremities	Left Side	Right Side
( ) Shoulder	( )	( )
( ) Upper Arm	( )	( )
( ) Elbow	( )	( )
( ) Forearm	( )	( )
( ) Wrist	( )	( )
( ) Hand	( )	( )
( ) Fingers	( )	( )

Lower Extremities	Left Side	Right Side
( ) Thigh	( )	( )
( ) Lower Leg	( )	( )
( ) Knee	( )	( )
( ) Ankle	( )	( )
( ) Foot	( )	( )
( ) Toes	( )	( )

Trunk	Left Side	Right Side
( ) Lower Back	( )	( )
( ) Upper Back	( )	( )
( ) Chest	( )	( )
( ) Abdomen	( )	( )
( ) Hip	( )	( )
( ) Groin	( )	( )
( ) _____	( )	( )

NATURE OF INJURY

( ) 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 employee injured this part(s) of the body previously or is there any pre-existing condition that could affect injury? Yes ( ) No ( )

Identify:

CONTRIBUTING FACTORS

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

WORK BEHAVIOR AT TIME OF INJURY

(Please check all items that pertain)

( ) 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

SAFETY EQUIPMENT IN USE

( ) Gloves	( ) Respirator	( ) Apron
( ) Face Shield	( ) Seat Belt	( ) Safety Glasses/Goggles

Explain in detail the accident/injury and what lead up to it. ***USE SEQUENCE OF EVENTS, 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 _____

SAFETY COMMITTEE EVALUATION

CORRECTIVE ACTION NEEDED

( ) Improve Design	( ) Discipline (Rule Enforcement)	( ) Improve Housekeeping	( ) Pers. Prat. Equipment
( ) Training	( ) Maintain Clean Work Area	( ) More Direct Supervision	( ) Job Safety Analysis
( ) Safety Devices	( ) Establish Rule/Procedures	( ) Repair or Replace Equip.	

SAFETY EQUIPMENT		SAFETY RULES	
( ) Not in Use	( ) Availability of Equipment	( ) Adequate	( ) Not Understood
( ) Training Required	( ) Proper Equipment	( ) Inadequate	( ) Enforcement Issue

RECOMMENDATION(S):

.....CHARACTER MATTERS.....