



**CAL STATE LA**

# Incident/Accident Investigation Report

EMPLOYEE INFORMATION			
<b>Employee Name:</b> <i>(print clearly)</i> Last, First		<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Today's Date:</b>
<b>Department:</b>	<b>Job Title:</b>		<b>Contact Number::</b>
<b>Supervisor's Name:</b>		<b>Supervisor's Phone:</b>	<b>Employer:</b> <input type="checkbox"/> CSULA <input type="checkbox"/> UAS
<b>TYPE of ACCIDENT / INCIDENT:</b>	<input type="checkbox"/> Slip / Trip / Fall	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Sprain / Strain
	<input type="checkbox"/> Contusion / Laceration / Avulsion	<input type="checkbox"/> Caught in / under / between	<input type="checkbox"/> Struck, contacted by / with / against
	<input type="checkbox"/> Exposure to	<input type="checkbox"/> Fracture	<input type="checkbox"/> Vehicle
<input type="checkbox"/> Other:			

INCIDENT / ACCIDENT INFORMATION			
<b>Date of incident:</b>	<b>Time of Incident:</b>	<b>Date Incident was Reported:</b>	<b>Date Last Worked:</b>
<b>Location where Incident/Accident Occurred:</b> (Ex. restroom, kitchen, parking lot, office, etc.) Be Specific.			
<b>Describe what happened:</b> (Use additional paper if needed)			
<b>Part of body Injured:</b> (Indicate "R", "L", or "B", where applicable - Check all that apply)			
<input type="checkbox"/> Head	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Lower Arm
<input type="checkbox"/> Hip /Thigh	<input type="checkbox"/> Lower Leg	<input type="checkbox"/> Eye	<input type="checkbox"/> Upper Back
<input type="checkbox"/> Upper Leg	<input type="checkbox"/> Ankle / Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Mid Back
<input type="checkbox"/> Elbow	<input type="checkbox"/> Hand / Fingers	<input type="checkbox"/> Knee	<input type="checkbox"/> Other: _____
Was employee transported to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, how was the employee transported? <input type="checkbox"/> Self <input type="checkbox"/> Ambulance <input type="checkbox"/> Other: _____	
Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was employee admitted other than observations? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has employee ever reported an injury before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, when and what part of the body?	
Was anyone else involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were there any witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name(s) of witnesses (if any):	

### CONTRIBUTING CAUSE

Conditions: (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Poor housekeeping; disorderly workplace                       | <input type="checkbox"/> Inadequate ventilation               |
| <input type="checkbox"/> Slip / Trip hazards   | <input type="checkbox"/> Weather conditions                   |
| <input type="checkbox"/> Workspace condition (congested or restricted access / egress) | <input type="checkbox"/> Exposure to hot / cold temperatures  |
| <input type="checkbox"/> Defective furniture, tools, equipment, or materials           | <input type="checkbox"/> No training or insufficient training |
| <input type="checkbox"/> Walking or working surface hazard                             | <input type="checkbox"/> Other (explain): _____               |

Activities: (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Improper body position / posture | <input type="checkbox"/> Using defective equipment            |
| <input type="checkbox"/> Mobile radio / cell phone use    | <input type="checkbox"/> Altering or modifying equipment      |
| <input type="checkbox"/> Unnecessary rushing              | <input type="checkbox"/> Not following appropriate procedures |
| <input type="checkbox"/> Distraction, teasing, horseplay  | <input type="checkbox"/> Inappropriate conduct                |
| <input type="checkbox"/> Improper lifting / bending       | <input type="checkbox"/> Awareness of surroundings            |
| <input type="checkbox"/> Other (explain): _____           |   |

### PREVENTATIVE / CORRECTIVE ACTION

Check (✓) actions taken to prevent recurrence. Mark with (P) corrective actions planned but not yet carried out.

- |  |  |
|--|--|
| <input type="checkbox"/> Training / instruction of person involved                       | <input type="checkbox"/> Request ergonomic assessment                    |
| <input type="checkbox"/> Improve Work Procedures   | <input type="checkbox"/> Request environmental assessment                |
| <input type="checkbox"/> Inform Staff / Managers of safe work procedures                 | <input type="checkbox"/> Correction of work area                         |
| <input type="checkbox"/> Perform job safety analysis                                     | <input type="checkbox"/> Recommend development / improvement to training |
| <input type="checkbox"/> Inform Staff / Managers of hazard and how to protect themselves | <input type="checkbox"/> Reassess work standards                         |
| <input type="checkbox"/> Notify Appropriate individuals                                  | <input type="checkbox"/> Reassignment of person                          |
| <input type="checkbox"/> Improve engineering / design                                    | <input type="checkbox"/> Improve housekeeping                            |
| <input type="checkbox"/> Tools, equipment, furniture repair or replacement               | <input type="checkbox"/> Other: _____                                    |

### RECOMMENDATIONS / COMMENTS


### INVESTIGATION REVIEW

- In-Person Interview       Phone Interview       Via E-mail Interview       Other: \_\_\_\_\_

Conducted by:

NAME (print):	SIGNATURE:	DATE:
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Reviewed By:

NAME (print):	SIGNATURE:	DATE:
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