# Deweyville Independent School District

**43200 Texas State Highway 87 South Orange, Texas 77632**

## Employee Incident/Accident Investigation Record

This form is for recordkeeping and loss control purposes. Do not send this form to TASB or to the Texas Workers' Compensation Commission (TWCC). Using this form will benefit the District in three ways:

1. Incident investigation assists the District in reducing or preventing future occupational injuries and illnesses.
2. This form requests all the information that TWCC says the District 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.
3. This form is a good source of information if the District needs to complete a first report of injury. The District must file a first report of injury with its insurance carrier for each on-the-job injury.

This incident is an:

☐ Injury ☐ Disease ☐ Fatality ☐ Near-Miss

| | |
|---|---|
| Today's Date: | Date reported: |
| District: | Campus: |
| Supervisor: | Supervisor Phone: |

Name of person involved: _____

Address: _____

Phone: _____ Sex: _____

DOB: _____ Social Security Number: _____

Employee's Occupation: _____

Length of service: _____

Date of incident: _____

Time & Day of incident: _____

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Specific location of incident: _____

Was it on employer's premises? ☐ Yes ☐ No

Job task at time of incident: _____

Employment category:

☐ Regular: Full-time ☐ Regular: Part-Time ☐ Temporary ☐ Seasonal ☐ Non-employee

Experience in occupation at time of incident:

☐ Less than one month ☐ One – Five months ☐ Six months – One year ☐ Five or more years

Employee was working:

☐ Alone ☐ With fellow workers ☐ Other: _____

Phase of employee's workday at time of injury:

☐ During break period ☐ During meal period ☐ Working overtime ☐ Entering or leaving building

☐ Performing work duties ☐ Other: _____

Witnessed accident? ☐ Yes ☐ No

Witnesses: _____

Name and address of treating physician: _____

_____

Phone: _____

Name and address of hospital: _____

_____

Part of body injured or affected:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Skull, scalp | ☐ Eye | ☐ Nose | ☐ Finger | ☐ Jaw | ☐ Pelvis |
| ☐ Neck | ☐ Spine | ☐ Mouth | ☐ Abdomen | ☐ Back | ☐ Chest |
| ☐ Shoulder | ☐ Thigh | ☐ Elbow | ☐ Forearm | ☐ Wrist | ☐ Hand |
| ☐ Lower leg | ☐ Knee | ☐ Ankle | ☐ Upper arm | ☐ Foot | ☐ Toe |
| ☐ Hip | ☐ Other: _____ | | | | |

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Nature of injury or illness:

☐ Puncture ☐ Irritation ☐ Chemical Exposure ☐ Bruise, contusion ☐ Laceration

☐ Infection ☐ Skin disorder ☐ Insect/animal bite ☐ Foreign body ☐ Burn

☐ Dislocation ☐ Muscle strain ☐ Amputation ☐ Muscle sprain ☐ Abrasion

☐ Hearing loss ☐ Heat/cold stress ☐ Cumulative trauma disorder

☐ Other: _____

Disposition:

☐ Days away from work: _____ ☐ Sent to doctor

☐ Restricted work days: _____ ☐ Sent to hospital

Return to work date: _____

Diagnosis: _____

_____

Severity:

☐ First aid ☐ Lost workdays ☐ Medical treatment ☐ Fatality

☐ Other (specify): _____

What condition of tools, equipment, or work area contributed to incident?

☐ Not applicable ☐ Equipment failure ☐ Inadequate ventilation

☐ Close clearance congestion ☐ Illumination ☐ Inadequate guards/barriers

☐ Floors/work surfaces ☐ Inadequate warning system ☐ Hazardous placement

☐ Inadequate housekeeping ☐ Equipment/workstation design ☐ Inadequate/improper PPE

☐ Defective tools/equipment/vehicle

What caused or influenced substandard condition?

☐ Not applicable ☐ Lack of skill ☐ Improper work surfaces

☐ Abuse or misuse ☐ Inadequate supervision ☐ Inadequate tools/equipment

☐ Inadequate purchasing ☐ Improper motivation ☐ Wear and tear

☐ Inadequate capacity ☐ Inadequate maintenance ☐ Lack of knowledge/training

☐ Inadequate engineering

What action or inaction contributed to the incident?

| | | |
|---|---|---|
| ☐ Not applicable | ☐ Improper loading | ☐ Failure to make secure |
| ☐ Improper technique | ☐ Under influence drugs/alcohol | ☐ Improper position |
| ☐ Nullified safety/control devices | ☐ Servicing operating equipment | ☐ Used defective equipment |
| ☐ Running/rushing/acting in haste | ☐ Horseplay/distractive action | ☐ Improper Lifting |
| ☐ Operating procedure deviation | ☐ Used equipment improperly | ☐ Unauthorized actions |
| ☐ Operating at improper speed | ☐ Used wrong tool/equipment | ☐ None |

☐ Other: _____

| | | | |
|---|---|---|---|
| Probable recurrence: | ☐ Frequent | ☐ Occasional | ☐ Rare |
| Loss severity potential: | ☐ Major | ☐ Serious | ☐ Minor |

Preventative measures: What corrective actions have been taken or are planned to prevent a recurrence?

| | | |
|---|---|---|
| ☐ Improve enforcement | ☐ Improve cleanup procedures | ☐ Rotation of employee |
| ☐ Repair/replace equipment | ☐ Improve storage/arrangements | ☐ Eliminate congestion |
| ☐ Identify/improve PPE | ☐ Improve/change work method | ☐ Improve illumination |
| ☐ Task analysis/procedure revision | ☐ Corrective Counseling | ☐ Install/revise guards/devices |
| ☐ Task analysis to be completed | ☐ Improve design/construction | ☐ Job reassignment of employee |
| ☐ Use other materials/supplies | ☐ Mandatory pre-job instructions | ☐ Improve ventilation |
| ☐ Reinstruction of employee | ☐ Other: _____ | |

Employee's description of incident (attach sheet for additional comments): _____

_____

_____

_____

_____

_____

_____

Signature of employee: _____

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Supervisor's description of incident (attach sheet for additional comments): _____

_____

_____

_____

_____

_____

Specific corrective actions or preventative measure taken:

| Corrective Action Taken | Person Responsible | Target Date | Date Completed |
|---|---|---|---|
| | | | |
| | | | |

Supervisor's signature: _____ Date: _____

Safety Coordinator's signature: _____ Date: _____

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## Witness Statement: Employee Incident/Accident

Name of witness: _____

Home address: _____

Phone: _____ Work Phone: _____

Date and time of incident/accident: _____

Where did the incident/accident happen? Be specific: _____

_____

_____

How close were you when the incident/accident occurred? _____

Did you see it? If not, how soon after did you arrive? _____

Was anyone injured? If so, who? _____

Were there other witnesses? If yes, list names: _____

_____

Describe what you saw and heard (attach additional sheets if needed): _____

_____

_____

_____

_____

_____

_____

Signature of witness: _____ Date: _____