

SUPERVISOR'S INVESTIGATION OF EMPLOYEE'S ACCIDENT/INCIDENT

1. LAST NAME OF INJURED	2. FIRST NAME	3. M.I.	4. SOCIAL SECURITY NUMBER	5. DATE OF BIRTH / /
6. SEX M <input type="checkbox"/> F <input type="checkbox"/>	7. DATE OF EMPLOYMENT IN UNIT / /	8. AGENCY NUMBER (COMPTROLLER'S CODE)		9. BUDGET NUMBER OF ASSIGNED UNIT
10. JOB CLASSIFICATION CODE	11. POSITION STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Floater (File where needed)	12. DATE OF INCIDENT / /	13. TIME OF INCIDENT am <input type="checkbox"/> pm <input type="checkbox"/>	

<p>A. EXTENT OF INJURY (Check one only)</p> <p><input type="checkbox"/> No injury (Incident only)</p> <p><input type="checkbox"/> Injury not requiring a TWCC-1S</p> <p><input type="checkbox"/> Medical</p> <p><input type="checkbox"/> Lost time only (more than one day)</p> <p><input type="checkbox"/> Medical and lost time</p> <p><input type="checkbox"/> Fatality</p> <hr/> <p>B. CATEGORY (Check one only)</p> <p><input type="checkbox"/> Occupational injury (accident)</p> <p><input type="checkbox"/> Occupational injury (aggressive behavior)</p> <p><input type="checkbox"/> Occupational illness/disease</p> <hr/> <p>C. SPECIFIC LOCATION OF OCCURENCE (Check one only)</p> <p>INDOORS:</p> <p>BUILDING INVENTORY NO. _____</p> <p><input type="checkbox"/> Auditorium</p> <p><input type="checkbox"/> Boiler room</p> <p><input type="checkbox"/> Canteen/Snack bar</p> <p><input type="checkbox"/> Cell block</p> <p><input type="checkbox"/> Classroom</p> <p><input type="checkbox"/> Closet</p> <p><input type="checkbox"/> Day room</p> <p><input type="checkbox"/> Dormitory/Living Room</p> <p><input type="checkbox"/> Elevator</p> <p><input type="checkbox"/> Food service area/Dining/Kitchen</p> <p><input type="checkbox"/> Garage</p> <p><input type="checkbox"/> Gymnasium/Recreation</p> <p><input type="checkbox"/> Hallway/Corridor</p> <p><input type="checkbox"/> Hospital/Clinic/Dispensary</p> <p><input type="checkbox"/> Laboratory</p> <p><input type="checkbox"/> Laundry</p> <p><input type="checkbox"/> Library</p> <p><input type="checkbox"/> Nursing station</p> <p><input type="checkbox"/> Office areas</p> <p><input type="checkbox"/> Program areas</p> <p><input type="checkbox"/> Ramp</p> <p><input type="checkbox"/> Sales store/Outlet</p> <p><input type="checkbox"/> Seclusion room</p> <p><input type="checkbox"/> Sleeping room</p> <p><input type="checkbox"/> Steps/Stairs/Stairway</p> <p><input type="checkbox"/> Storage area</p> <p><input type="checkbox"/> Waiting room</p> <p><input type="checkbox"/> Workshop/technical traders</p> <p><input type="checkbox"/> Other specify _____</p> <p>OUTDOORS:</p> <p><input type="checkbox"/> Athletic field</p> <p><input type="checkbox"/> Campus</p> <p><input type="checkbox"/> Grounds</p> <p><input type="checkbox"/> Highway/Road/Street</p> <p><input type="checkbox"/> Loading dock</p> <p><input type="checkbox"/> Park or recreation area</p> <p><input type="checkbox"/> Parking lot</p> <p><input type="checkbox"/> Roof</p> <p><input type="checkbox"/> Sidewalk</p> <p><input type="checkbox"/> Steps/Stairs/Stairway</p> <p><input type="checkbox"/> Storage area</p> <p><input type="checkbox"/> Swimming pool area</p> <p><input type="checkbox"/> Tower</p> <p><input type="checkbox"/> Other (specify) _____</p>	<p>D. ACTIVITY ENGAGED IN BY INJURED AT TIME OF INJURY (Check one only)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Bathing</td> <td><input type="checkbox"/> Moving</td> </tr> <tr> <td><input type="checkbox"/> Buffing</td> <td><input type="checkbox"/> Operating</td> </tr> <tr> <td><input type="checkbox"/> Carrying</td> <td><input type="checkbox"/> Pulling</td> </tr> <tr> <td><input type="checkbox"/> Cleaning</td> <td><input type="checkbox"/> Pushing</td> </tr> <tr> <td><input type="checkbox"/> Climbing</td> <td><input type="checkbox"/> Reaching</td> </tr> <tr> <td><input type="checkbox"/> Cutting</td> <td><input type="checkbox"/> Redirecting</td> </tr> <tr> <td><input type="checkbox"/> Descending</td> <td><input type="checkbox"/> Restraining</td> </tr> <tr> <td><input type="checkbox"/> Digging</td> <td><input type="checkbox"/> Running</td> </tr> <tr> <td><input type="checkbox"/> Dressing</td> <td><input type="checkbox"/> Sanding</td> </tr> <tr> <td><input type="checkbox"/> Driving</td> <td><input type="checkbox"/> Sawing</td> </tr> <tr> <td><input type="checkbox"/> Eating</td> <td><input type="checkbox"/> Searching</td> </tr> <tr> <td><input type="checkbox"/> Escorting</td> <td><input type="checkbox"/> Securing</td> </tr> <tr> <td><input type="checkbox"/> Exercising</td> <td><input type="checkbox"/> Sitting</td> </tr> <tr> <td><input type="checkbox"/> Feeding</td> <td><input type="checkbox"/> Standing</td> </tr> <tr> <td><input type="checkbox"/> Grinding</td> <td><input type="checkbox"/> Stripping</td> </tr> <tr> <td><input type="checkbox"/> Grooming</td> <td><input type="checkbox"/> Turning</td> </tr> <tr> <td><input type="checkbox"/> Jumping</td> <td><input type="checkbox"/> Typing</td> </tr> <tr> <td><input type="checkbox"/> Loading</td> <td><input type="checkbox"/> Walking</td> </tr> <tr> <td><input type="checkbox"/> Mopping</td> <td><input type="checkbox"/> Other (specify) _____</td> </tr> </table> <hr/> <p>E. BODY PART INJURED (Most Serious)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Anide</td> <td><input type="checkbox"/> Internal organ</td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td><input type="checkbox"/> Jaw</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Knee(s)</td> </tr> <tr> <td><input type="checkbox"/> Buttocks</td> <td><input type="checkbox"/> Leg(s)</td> </tr> <tr> <td><input type="checkbox"/> Cheek</td> <td><input type="checkbox"/> Mouth</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Neck</td> </tr> <tr> <td><input type="checkbox"/> Chin</td> <td><input type="checkbox"/> Nose</td> </tr> <tr> <td><input type="checkbox"/> Ear(s)</td> <td><input type="checkbox"/> Pelvis</td> </tr> <tr> <td><input type="checkbox"/> Eye(s)</td> <td><input type="checkbox"/> Rib(s)</td> </tr> <tr> <td><input type="checkbox"/> Foot-Foot</td> <td><input type="checkbox"/> Scalp</td> </tr> <tr> <td><input type="checkbox"/> Finger/Thumb(s)</td> <td><input type="checkbox"/> Shoulder</td> </tr> <tr> <td><input type="checkbox"/> Forehead</td> <td><input type="checkbox"/> Toe(s)</td> </tr> <tr> <td><input type="checkbox"/> Groin</td> <td><input type="checkbox"/> Wrist(s)</td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Other (specify) _____</td> </tr> <tr> <td><input type="checkbox"/> Hips</td> <td></td> </tr> </table> <hr/> <p>F. TYPE OF INJURY (Check primary one)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Abrasion</td> <td><input type="checkbox"/> Heat exhaustion</td> </tr> <tr> <td><input type="checkbox"/> Amputation</td> <td><input type="checkbox"/> Hernia</td> </tr> <tr> <td><input type="checkbox"/> Bite</td> <td><input type="checkbox"/> Infection</td> </tr> <tr> <td><input type="checkbox"/> Bruise</td> <td><input type="checkbox"/> Inflammation</td> </tr> <tr> <td><input type="checkbox"/> Burn</td> <td><input type="checkbox"/> Internal injuries</td> </tr> <tr> <td><input type="checkbox"/> Concussion</td> <td><input type="checkbox"/> Puncture</td> </tr> <tr> <td><input type="checkbox"/> Cut</td> <td><input type="checkbox"/> Repetitive Trauma</td> </tr> <tr> <td><input type="checkbox"/> Dermatitis</td> <td><input type="checkbox"/> Rupture</td> </tr> <tr> <td><input type="checkbox"/> Dislocation</td> <td><input type="checkbox"/> Scratch</td> </tr> <tr> <td><input type="checkbox"/> Foreign object</td> <td><input type="checkbox"/> Shock</td> </tr> <tr> <td><input type="checkbox"/> Fracture</td> <td><input type="checkbox"/> Sprain/Strain</td> </tr> <tr> <td><input type="checkbox"/> Frostbite</td> <td><input type="checkbox"/> Sting</td> </tr> <tr> <td><input type="checkbox"/> Hearing loss</td> <td><input type="checkbox"/> Other (specify) _____</td> </tr> <tr> <td><input type="checkbox"/> Heart attack</td> <td></td> </tr> </table> <hr/> <p>G. TYPE OF OCCURRENCE (Check one only)</p> <p><input type="checkbox"/> Aggression (client, inmate, patient)</p> <p><input type="checkbox"/> Bodily reaction (drug, medication)</p> <p><input type="checkbox"/> Caught in, on, under, or between</p> <p><input type="checkbox"/> Contact with chemicals</p> <p><input type="checkbox"/> Contact with electric current</p> <p><input type="checkbox"/> Contact with temperature extremes</p> <p><input type="checkbox"/> Fall on same level</p>	<input type="checkbox"/> Bathing	<input type="checkbox"/> Moving	<input type="checkbox"/> Buffing	<input type="checkbox"/> Operating	<input type="checkbox"/> Carrying	<input type="checkbox"/> Pulling	<input type="checkbox"/> Cleaning	<input type="checkbox"/> Pushing	<input type="checkbox"/> Climbing	<input type="checkbox"/> Reaching	<input type="checkbox"/> Cutting	<input type="checkbox"/> Redirecting	<input type="checkbox"/> Descending	<input type="checkbox"/> Restraining	<input type="checkbox"/> Digging	<input type="checkbox"/> Running	<input type="checkbox"/> Dressing	<input type="checkbox"/> Sanding	<input type="checkbox"/> Driving	<input type="checkbox"/> Sawing	<input type="checkbox"/> Eating	<input type="checkbox"/> Searching	<input type="checkbox"/> Escorting	<input type="checkbox"/> Securing	<input type="checkbox"/> Exercising	<input type="checkbox"/> Sitting	<input type="checkbox"/> Feeding	<input type="checkbox"/> Standing	<input type="checkbox"/> Grinding	<input type="checkbox"/> Stripping	<input type="checkbox"/> Grooming	<input type="checkbox"/> Turning	<input type="checkbox"/> Jumping	<input type="checkbox"/> Typing	<input type="checkbox"/> Loading	<input type="checkbox"/> Walking	<input type="checkbox"/> Mopping	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Anide	<input type="checkbox"/> Internal organ	<input type="checkbox"/> Arm	<input type="checkbox"/> Jaw	<input type="checkbox"/> Back	<input type="checkbox"/> Knee(s)	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Leg(s)	<input type="checkbox"/> Cheek	<input type="checkbox"/> Mouth	<input type="checkbox"/> Chest	<input type="checkbox"/> Neck	<input type="checkbox"/> Chin	<input type="checkbox"/> Nose	<input type="checkbox"/> Ear(s)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Rib(s)	<input type="checkbox"/> Foot-Foot	<input type="checkbox"/> Scalp	<input type="checkbox"/> Finger/Thumb(s)	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Forehead	<input type="checkbox"/> Toe(s)	<input type="checkbox"/> Groin	<input type="checkbox"/> Wrist(s)	<input type="checkbox"/> Hand	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Hips		<input type="checkbox"/> Abrasion	<input type="checkbox"/> Heat exhaustion	<input type="checkbox"/> Amputation	<input type="checkbox"/> Hernia	<input type="checkbox"/> Bite	<input type="checkbox"/> Infection	<input type="checkbox"/> Bruise	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Burn	<input type="checkbox"/> Internal injuries	<input type="checkbox"/> Concussion	<input type="checkbox"/> Puncture	<input type="checkbox"/> Cut	<input type="checkbox"/> Repetitive Trauma	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rupture	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Scratch	<input type="checkbox"/> Foreign object	<input type="checkbox"/> Shock	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Frostbite	<input type="checkbox"/> Sting	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Heart attack		<p>G. CONTINUED</p> <p><input type="checkbox"/> Fall on different level</p> <p><input type="checkbox"/> Over-exertion (exceeding physical ability)</p> <p><input type="checkbox"/> Overexposure to environmental hazards (noise, toxic)</p> <p><input type="checkbox"/> Repetitive Motion</p> <p><input type="checkbox"/> Slip (not a fall)</p> <p><input type="checkbox"/> Struck against (rough, sharp object)</p> <p><input type="checkbox"/> Struck by falling moving object</p> <p><input type="checkbox"/> Other (specify) _____</p> <hr/> <p>H. PHYSICAL THING MOST CLOSELY ASSOCIATED WITH OCCURENCE (Check one)</p> <p><input type="checkbox"/> Aircraft</p> <p><input type="checkbox"/> Air pressure</p> <p><input type="checkbox"/> Animal (snake, dog, horse, etc.)</p> <p><input type="checkbox"/> Athletic equipment (baseball, bat, dart, etc.)</p> <p><input type="checkbox"/> Attachments (belt, pulley, gear, shaft)</p> <p><input type="checkbox"/> Cabinet</p> <p><input type="checkbox"/> Chemical (solid, liquid, or gas)</p> <p><input type="checkbox"/> Computer</p> <p><input type="checkbox"/> Clothing</p> <p><input type="checkbox"/> Container (bottle, box, barrel, cylinder, etc.)</p> <p><input type="checkbox"/> Curb</p> <p><input type="checkbox"/> Doors (automatic, manual, revolving)</p> <p><input type="checkbox"/> Drugs or medicine</p> <p><input type="checkbox"/> Dust</p> <p><input type="checkbox"/> Electrical apparatus</p> <p><input type="checkbox"/> Elevator, escalator</p> <p><input type="checkbox"/> Explosives</p> <p><input type="checkbox"/> Eyewear</p> <p><input type="checkbox"/> Fan</p> <p><input type="checkbox"/> Fire, flame, smoke</p> <p><input type="checkbox"/> Floor</p> <p><input type="checkbox"/> Food products</p> <p><input type="checkbox"/> Fumes</p> <p><input type="checkbox"/> Furniture, fixtures</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Glass items</p> <p><input type="checkbox"/> Gun</p> <p><input type="checkbox"/> Ground (earth)</p> <p><input type="checkbox"/> Hand tool</p> <p><input type="checkbox"/> Heating equipment</p> <p><input type="checkbox"/> Hoisting equipment</p> <p><input type="checkbox"/> Icy condition</p> <p><input type="checkbox"/> Infectious or parasitic agent</p> <p><input type="checkbox"/> Inmate, client, employee</p> <p><input type="checkbox"/> Insect</p> <p><input type="checkbox"/> Kitchen equipment</p> <p><input type="checkbox"/> Knife</p> <p><input type="checkbox"/> Lighting fixture and equipment</p> <p><input type="checkbox"/> Ladder, scaffold</p> <p><input type="checkbox"/> Locker</p> <p><input type="checkbox"/> Machine</p> <p><input type="checkbox"/> Material handling equipment</p> <p><input type="checkbox"/> Metal</p> <p><input type="checkbox"/> Mineral items (asphalt, clay, gravel, etc.)</p> <p><input type="checkbox"/> Motor vehicle</p> <p><input type="checkbox"/> Needle</p> <p><input type="checkbox"/> Office equipment (chair, desk, cabinet, etc.)</p> <p><input type="checkbox"/> Paint</p> <p><input type="checkbox"/> Particle</p> <p><input type="checkbox"/> Pavement</p> <p><input type="checkbox"/> Person (other than client, inmate, employee)</p> <p><input type="checkbox"/> Pipe</p> <p><input type="checkbox"/> Platform, dock, ramp</p>
<input type="checkbox"/> Bathing	<input type="checkbox"/> Moving																																																																																																	
<input type="checkbox"/> Buffing	<input type="checkbox"/> Operating																																																																																																	
<input type="checkbox"/> Carrying	<input type="checkbox"/> Pulling																																																																																																	
<input type="checkbox"/> Cleaning	<input type="checkbox"/> Pushing																																																																																																	
<input type="checkbox"/> Climbing	<input type="checkbox"/> Reaching																																																																																																	
<input type="checkbox"/> Cutting	<input type="checkbox"/> Redirecting																																																																																																	
<input type="checkbox"/> Descending	<input type="checkbox"/> Restraining																																																																																																	
<input type="checkbox"/> Digging	<input type="checkbox"/> Running																																																																																																	
<input type="checkbox"/> Dressing	<input type="checkbox"/> Sanding																																																																																																	
<input type="checkbox"/> Driving	<input type="checkbox"/> Sawing																																																																																																	
<input type="checkbox"/> Eating	<input type="checkbox"/> Searching																																																																																																	
<input type="checkbox"/> Escorting	<input type="checkbox"/> Securing																																																																																																	
<input type="checkbox"/> Exercising	<input type="checkbox"/> Sitting																																																																																																	
<input type="checkbox"/> Feeding	<input type="checkbox"/> Standing																																																																																																	
<input type="checkbox"/> Grinding	<input type="checkbox"/> Stripping																																																																																																	
<input type="checkbox"/> Grooming	<input type="checkbox"/> Turning																																																																																																	
<input type="checkbox"/> Jumping	<input type="checkbox"/> Typing																																																																																																	
<input type="checkbox"/> Loading	<input type="checkbox"/> Walking																																																																																																	
<input type="checkbox"/> Mopping	<input type="checkbox"/> Other (specify) _____																																																																																																	
<input type="checkbox"/> Anide	<input type="checkbox"/> Internal organ																																																																																																	
<input type="checkbox"/> Arm	<input type="checkbox"/> Jaw																																																																																																	
<input type="checkbox"/> Back	<input type="checkbox"/> Knee(s)																																																																																																	
<input type="checkbox"/> Buttocks	<input type="checkbox"/> Leg(s)																																																																																																	
<input type="checkbox"/> Cheek	<input type="checkbox"/> Mouth																																																																																																	
<input type="checkbox"/> Chest	<input type="checkbox"/> Neck																																																																																																	
<input type="checkbox"/> Chin	<input type="checkbox"/> Nose																																																																																																	
<input type="checkbox"/> Ear(s)	<input type="checkbox"/> Pelvis																																																																																																	
<input type="checkbox"/> Eye(s)	<input type="checkbox"/> Rib(s)																																																																																																	
<input type="checkbox"/> Foot-Foot	<input type="checkbox"/> Scalp																																																																																																	
<input type="checkbox"/> Finger/Thumb(s)	<input type="checkbox"/> Shoulder																																																																																																	
<input type="checkbox"/> Forehead	<input type="checkbox"/> Toe(s)																																																																																																	
<input type="checkbox"/> Groin	<input type="checkbox"/> Wrist(s)																																																																																																	
<input type="checkbox"/> Hand	<input type="checkbox"/> Other (specify) _____																																																																																																	
<input type="checkbox"/> Hips																																																																																																		
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Heat exhaustion																																																																																																	
<input type="checkbox"/> Amputation	<input type="checkbox"/> Hernia																																																																																																	
<input type="checkbox"/> Bite	<input type="checkbox"/> Infection																																																																																																	
<input type="checkbox"/> Bruise	<input type="checkbox"/> Inflammation																																																																																																	
<input type="checkbox"/> Burn	<input type="checkbox"/> Internal injuries																																																																																																	
<input type="checkbox"/> Concussion	<input type="checkbox"/> Puncture																																																																																																	
<input type="checkbox"/> Cut	<input type="checkbox"/> Repetitive Trauma																																																																																																	
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Rupture																																																																																																	
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Scratch																																																																																																	
<input type="checkbox"/> Foreign object	<input type="checkbox"/> Shock																																																																																																	
<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain/Strain																																																																																																	
<input type="checkbox"/> Frostbite	<input type="checkbox"/> Sting																																																																																																	
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Other (specify) _____																																																																																																	
<input type="checkbox"/> Heart attack																																																																																																		

Continued On Other Side

ATTACHMENT F
Page 1
HSC OP 70.13
April 30, 2012

H. CONTINUED <input type="checkbox"/> Pole <input type="checkbox"/> Power tool or machinery (lathe, saw, etc.) <input type="checkbox"/> Radiating equipment (microwave, x-ray, etc.) <input type="checkbox"/> Receptacle <input type="checkbox"/> Smoke <input type="checkbox"/> Stair, step <input type="checkbox"/> Sun <input type="checkbox"/> Trench/Ditch <input type="checkbox"/> Vegetation <input type="checkbox"/> Weather <input type="checkbox"/> Wood <input type="checkbox"/> Other (specify) _____	I. CONTINUED <input type="checkbox"/> Riding moving equipment not designed for passengers <input type="checkbox"/> Unobservant (daydreaming, inattentive, etc.) <input type="checkbox"/> Using unsafe/defective tool, material equipment <input type="checkbox"/> Using wrong tool, material equipment <input type="checkbox"/> Working/Walking under suspended load (crane, hoist, derrick) <input type="checkbox"/> Working in a confined space without proper safeguard <input type="checkbox"/> Working without adequate lighting <input type="checkbox"/> Other (specify) _____	J. CONTINUED <input type="checkbox"/> Unsafe/defective hand or electric tools <input type="checkbox"/> Unsafe equipment <input type="checkbox"/> Unsafe material <input type="checkbox"/> Unsafe vehicle <input type="checkbox"/> Unshored trench, excavation, etc. <input type="checkbox"/> Walkway, sidewalk, pavement <input type="checkbox"/> Other (specify) _____
J. CONDITION (PHYSICAL HAZARD) ASSOCIATED WITH OCCURRENCE (Check one)		
I. ACT/PRACTICE ASSOCIATED WITH OCCURRENCE (Check one only) <input type="checkbox"/> Contact with electrical source (tool, device, wire, etc.) <input type="checkbox"/> Entering an unauthorized area <input type="checkbox"/> Failure to practice safe driving technique <input type="checkbox"/> Failure to use established route or taking short cut <input type="checkbox"/> Failure to use handrail, grab bar <input type="checkbox"/> Failure to use lockout device <input type="checkbox"/> Failure to use personal protective equipment (PPE) <input type="checkbox"/> Failure to warn of known hazards (i.e. no safety sign, light, barricade, instruction, etc.) <input type="checkbox"/> Failure to wear appropriate dress (shoes, shirt, blouse) <input type="checkbox"/> Handling (of object, material, item, thing) <input type="checkbox"/> Horseplay <input type="checkbox"/> Improper mixing or storing (non-compatible material, chemicals, etc.) <input type="checkbox"/> Improper placing or storing (materials, tools, equipment) <input type="checkbox"/> Lifting (including position, stance) <input type="checkbox"/> Making safety devices inoperative <input type="checkbox"/> No unsafe act/practice on the part of employee <input type="checkbox"/> Operating/Working at unsafe speed <input type="checkbox"/> Operating without proper authority/clearance <input type="checkbox"/> Over or unnecessary exposure to hazards (gas, fumes, dust, chemicals, mist, radiation, etc.) <input type="checkbox"/> Repairing or servicing moving object/thing (machine, equipment, etc.)	<input type="checkbox"/> Congested area <input type="checkbox"/> Electrical hazard (uninsulated wire, overloaded circuit, inadequate ground, etc.) <input type="checkbox"/> Excessive noise <input type="checkbox"/> Harmful animals/insects/reptiles <input type="checkbox"/> Health hazards (radiation, gas, fumes, dust, vapors, etc.) <input type="checkbox"/> Improper housekeeping <input type="checkbox"/> Improperly stored chemicals, hazardous substances <input type="checkbox"/> Inadequate ventilation <input type="checkbox"/> Inadequate or no warning signs <input type="checkbox"/> Layout or design (office, shop, equipment) <input type="checkbox"/> Lighting <input type="checkbox"/> Mislabeled/Unlabeled chemicals, hazardous materials etc. <input type="checkbox"/> No unsafe condition <input type="checkbox"/> Open trench, hole, ditch, sharp drop-off <input type="checkbox"/> Poisonous vegetation (oak, ivy, etc.) <input type="checkbox"/> Protruding object (nail, wire, splinter, etc.) <input type="checkbox"/> Rough/Sharp objects <input type="checkbox"/> Slipping or tripping hazard <input type="checkbox"/> Step, stairs, ladder, or other working surfaces <input type="checkbox"/> Unguarded machine, belt, pulley, roller, etc.	K. DID A RULE, POLICY OR PROCEDURE APPLY TO THIS MISHAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
I. WAS THE RULE, POLICY OR PROCEDURE FOLLOWED? If no, explain in section N.		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
M. ACTION(S) TAKEN OR PLANNED TO PREVENT RECURRENCE? (Check all that apply)		
<input type="checkbox"/> Action taken with employee for violating rules, regulations or procedures <input type="checkbox"/> All employees were made aware of the occurrence, cause, consequence, and action taken to prevent recurrence <input type="checkbox"/> Employee give basic training <input type="checkbox"/> Employee given refresher or remedial training <input type="checkbox"/> Existing rule, regulation or standard (SOP) enforced <input type="checkbox"/> Existing rule, regulation or standard (SOP) revised <input type="checkbox"/> New rule, regulation or standard prepared <input type="checkbox"/> Physical hazard(s) corrected Other positive action taken _____		

N. DESCRIBE BRIEFLY IN NARRATIVE FORM THE CIRCUMSTANCES THAT LED TO AND CAUSED THIS OCCURRENCE.

ANSWER: WHO? WHAT? WHERE? WHEN? WHY? AND HOW? (Use additional sheet if necessary)

		/ /	()
INJURED'S IMMEDIATE SUPERVISOR (print)	SIGNATURE	DATE	PHONE
SECTION/DEPARTMENT/DIVISION ADDITIONAL DUTY SAFETY OFFICER COMMENT:			
SIGNATURE	DATE: / /		
SECTION/DEPARTMENT/DIVISION HEAD COMMENT:			
SIGNATURE	DATE: / /		
AGENCY OR FACILITY SAFETY MANAGER COMMENT:			
SIGNATURE	DATE: / /		