

Root Cause(s) of Incident:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

SECTION II: POSITIVE SAFETY BEHAVIOR

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SECTION III: AT-RISK SAFETY BEHAVIOR

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SECTION IV: CORRECTIVE ACTION

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SECTION V: BACKGROUND INFORMATION

Name: _____

Home Address: _____
Number/Street/Apartment #

City State Zip Code

Home Telephone#: _____ Date of Birth: _____ Age: _____

Date Incident Reported: _____ Time Incident Was Reported: _____

Job Title: _____

Start Time: _____ End Time: _____

Weather Conditions at time of Incident: _____

Was First Aid Provided? YES NO Was anyone exposed to blood borne pathogens? YES No

What was the nature of the injury?

<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Animal/Insect Bite	<input type="checkbox"/> Inhalation - Fumes/Vapors/Particles
<input type="checkbox"/> Body Motion	<input type="checkbox"/> Slip/Trip/Fall	<input type="checkbox"/> Noise Exposure	<input type="checkbox"/> Foreign Object in Eye
<input type="checkbox"/> Fracture	<input type="checkbox"/> Blood/Bodily Fluid	<input type="checkbox"/> Other	<input type="checkbox"/> Caught In/Under/Between
<input type="checkbox"/> Burn(s)	<input type="checkbox"/> Muscle Strain	<input type="checkbox"/> Needle Stick	<input type="checkbox"/> Struck By/Struck Against

Comments: _____

What part of the body was affected?

<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Chest/Torso	<input type="checkbox"/> Back	<input type="checkbox"/> Hand/Right	<input type="checkbox"/> Foot/Right
<input type="checkbox"/> Mouth/Teeth	<input type="checkbox"/> Nose	<input type="checkbox"/> Shoulder/Left	<input type="checkbox"/> Shoulder/Right	<input type="checkbox"/> Leg/Left	<input type="checkbox"/> Foot/Left
<input type="checkbox"/> Eye/Left	<input type="checkbox"/> Eye/Right	<input type="checkbox"/> Arm/Left	<input type="checkbox"/> Arm/Right	<input type="checkbox"/> Leg/Right	<input type="checkbox"/> Other
<input type="checkbox"/> Ear/Left	<input type="checkbox"/> Ear/Right	<input type="checkbox"/> Hand/Left	<input type="checkbox"/> Finger(s)	<input type="checkbox"/> Toe(s)	

Comments: _____

Where was the employee positioned and where were other employees positioned? Why?

SECTION VI: BODY POSITIONING

What ergonomic factors were present?

<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Twisting	<input type="checkbox"/> Lifting Too Much	<input type="checkbox"/> Other
<input type="checkbox"/> Forearm Exertion	<input type="checkbox"/> Awkward Position	<input type="checkbox"/> Wrong Tools	
<input type="checkbox"/> Vibration	<input type="checkbox"/> Improper Lifting	<input type="checkbox"/> Heavy Tools	
<input type="checkbox"/> Poor Work Height	<input type="checkbox"/> Reaching Above Shoulder	<input type="checkbox"/> Bending	

Comments: _____

SECTION VII: CONTRIBUTING FACTORS		
Were There time pressures? YES <input type="checkbox"/> NO <input type="checkbox"/>	Were there illness or fatigue factors (sleep deprivation)? YES <input type="checkbox"/> NO <input type="checkbox"/>	Was there high workload? YES <input type="checkbox"/> NO <input type="checkbox"/>
Inaccurate risk perceptions? YES <input type="checkbox"/> NO <input type="checkbox"/>	Were there distractions or interruptions? YES <input type="checkbox"/> NO <input type="checkbox"/>	Was there a lack of experience? YES <input type="checkbox"/> NO <input type="checkbox"/>
Multi-tasking requirements? YES <input type="checkbox"/> NO <input type="checkbox"/>	Personal stress issues (that employee shared)? YES <input type="checkbox"/> NO <input type="checkbox"/>	Mental short-cuts? YES <input type="checkbox"/> NO <input type="checkbox"/>
Was the work monotonous? YES <input type="checkbox"/> NO <input type="checkbox"/>	Limited short-term memory in evidence? YES <input type="checkbox"/> NO <input type="checkbox"/>	Complacency or overconfidence? YES <input type="checkbox"/> NO <input type="checkbox"/>
Assumptions? YES <input type="checkbox"/> NO <input type="checkbox"/>	Mind-set (thinking about other things)? YES <input type="checkbox"/> NO <input type="checkbox"/>	Habit/Pattern? YES <input type="checkbox"/> NO <input type="checkbox"/>
Was a Job Briefing/Tailgate held?		
Was there precise communication regarding the work processes and procedures? YES <input type="checkbox"/> NO <input type="checkbox"/>		
When was task training provided to the employee (routine/non-routine)? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Were the job functions clearly understood? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Is the job structured to encourage deviation from job procedures (incentive, time deadlines, etc.)? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Did employees deviate from the known job procedure? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Were any tasks too difficult to perform? (Individually or with how many were assigned to the job) YES <input type="checkbox"/> NO <input type="checkbox"/>		
Were the goals, roles or responsibilities unclear? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Were there changes or departure from routine? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Was the appropriate PPE used? YES <input type="checkbox"/> NO <input type="checkbox"/>		
What guarding equipment was or was not in place (LOTO, barricades / barriers, etc.)? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Was the correct equipment/tool used? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Were there confusing displays or controls? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Was Housekeeping an issue? YES <input type="checkbox"/> NO <input type="checkbox"/>		

SECTION VII: CONTRIBUTING FACTORS (Continued)

Were slip/trip/fall hazards present? YES NO

Environmental conditions (light, noise, air quality, temperature, ventilation, radiation, vibrations, etc.)? YES NO

I REPRESENT THAT THE INFORMATION PROVIDED IN THIS DOCUMENT IS TRUTHFUL AND TO THE BEST OF MY KNOWLEDGE. *(Individual conducting the incident investigation please print your name, sign, and date)*

Print Name: _____

Signature: _____

Date: _____